

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42501

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

JOSEPH

ZEMEL

2. Date of Death

Month

Day

Year

DECEMBER

24,

1999

3. Time of Death

5:45 A.M.

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

102-07-1480

6. Sex

M 20 F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

JUNE 15, 1911

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

XX Yes 20 No

10e. Street and Number

6121 MONTROSS ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

10 Never Married 20 Married

XX Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FUEL SALES

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

SAM ZEMEL

18. Mother's Name (First, Middle, Maiden Surname)

ROSE BLANDER

19a. Informant's Name/Relationship (Type, Print)

JANICE L. ROCKWELL/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10304-NOLAN DRIVE, ROCKVILLE, MARYLAND 20850

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL CEMETERY

12/26

1999

20c. Location - City or Town, State

OLNEY, MARYLAND

STEIN HEBREW MEMORIAL, F.H.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

232-CARROLL STREET, NORTHWEST
WASHINGTON, D.C. 20012

23a. Part I. Enter this disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC CARDIOMYOPATHY
Due to (or as a consequence of):b. CORONARY ARTERY DISEASE
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ESSENTIAL HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural

20 Accident

30 Suicide

40 Homicide

50 Pending investigation

60 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15084

29d. Date signed (Month, Day, Year)

December 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. D. PATEL, MD 6121 MONTROSS RD, Rockville, MD 20852

31. Date filed (Month, Day, Year)

DEC 29 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

DEC 2 1960

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

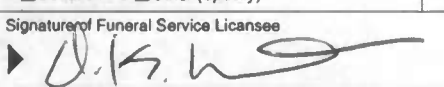
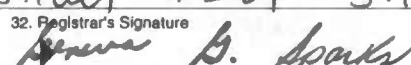
State of Maryland / Department of Health and Mental Hygiene

99 42502

Amended Item#23apt1&2 perPhyG779 1/18/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Benjamin L. Abrams						2. Date of Death Month Day Year Dec. 11, 1999		3. Time of Death 4:02 PM	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital						4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-48-1128		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 98 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 10, 1901		9. Birthplace (State or Foreign Country) New Jersey	
	Usual Residence of Decedent									
10a. State MD		10b. County Prince Georges		10c. City, Town or Location Silver Spring				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 8335 12th Ave.				10f. Zip Code 20903		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 3				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman			16b. Kind of Business/Industry Novelties			
17. Father's Name (First, Middle, Last) Louis Abrams						18. Mother's Name (First, Middle, Maiden Surname) Dora Eskin				
19a. Informant's Name/Relationship (Type, Print) P. Earle Abrams/ Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10919 Lombardy Rd., Silver Spring, MD 20901				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King David Memorial Gdn.		Date Dec. 14, 1999		20c. Location - City or Town, State Falls Church, VA		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of): RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HYPERTENSION Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death WEEKS 1 hour	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. ASHD NIDDM								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier OKI KWON, M.D.						29c. License number D-30927		29d. Date signed (Month, Day, Year) Dec. 12, 1999		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) OKI KWON, M.D. 1104 Spring Street #201 Silver Spring, MD 20910										
31. Date filed (Month, Day, Year) DEC 14 1999				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 99 42503

Amended Item#5 perPhyG779 1/15/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GREGORY BARLOW				2. Date of Death Month Day Year DECEMBER 30 1999		3. Time of Death 12:40 AM	
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSP				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funeral Director	5. Social Security Number 212568191		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 47 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 04, 1952	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County		10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 310 E. 22 1/2 STREET				10f. Zip Code 21218		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE WORKER			16b. Kind of Business/Industry TOWSON MALL	
17. Father's Name (First, Middle, Last) LEWIS BARLOW				18. Mother's Name (First, Middle, Maiden Surname) DOROTHY BOST				
19a. Informant's Name/Relationship (Type, Print) SUNDAY POWELL / SISTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 945 NORTH HILL RD BALTO. MD 21218				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION		Data		20c. Location - City or Town, State JAN. 06, 2000 LANDSDOWN, MD		
21. Signature of Funeral Service Licensee Leander M. Coler				22. Name and Address of Facility TRI-STATE FUNERAL SERVICE 108 W. NORTH AVE BALTO. MD				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Septic shock Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cocaine, opiate positive in urine								Approximate Interval Between Onset and Death 1 day 1 day
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cocaine, opiate positive in urine						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Loveen Puthumana, MD				29c. License number AT 2438946 C12		29d. Date signed (Month, Day, Year) DECEMBER, 30, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOVEEN J PUTHUMANA				201 East University PKW Baltimore, Maryland 21218				
31. Date filed (Month, Day, Year) JAN 14 2000		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

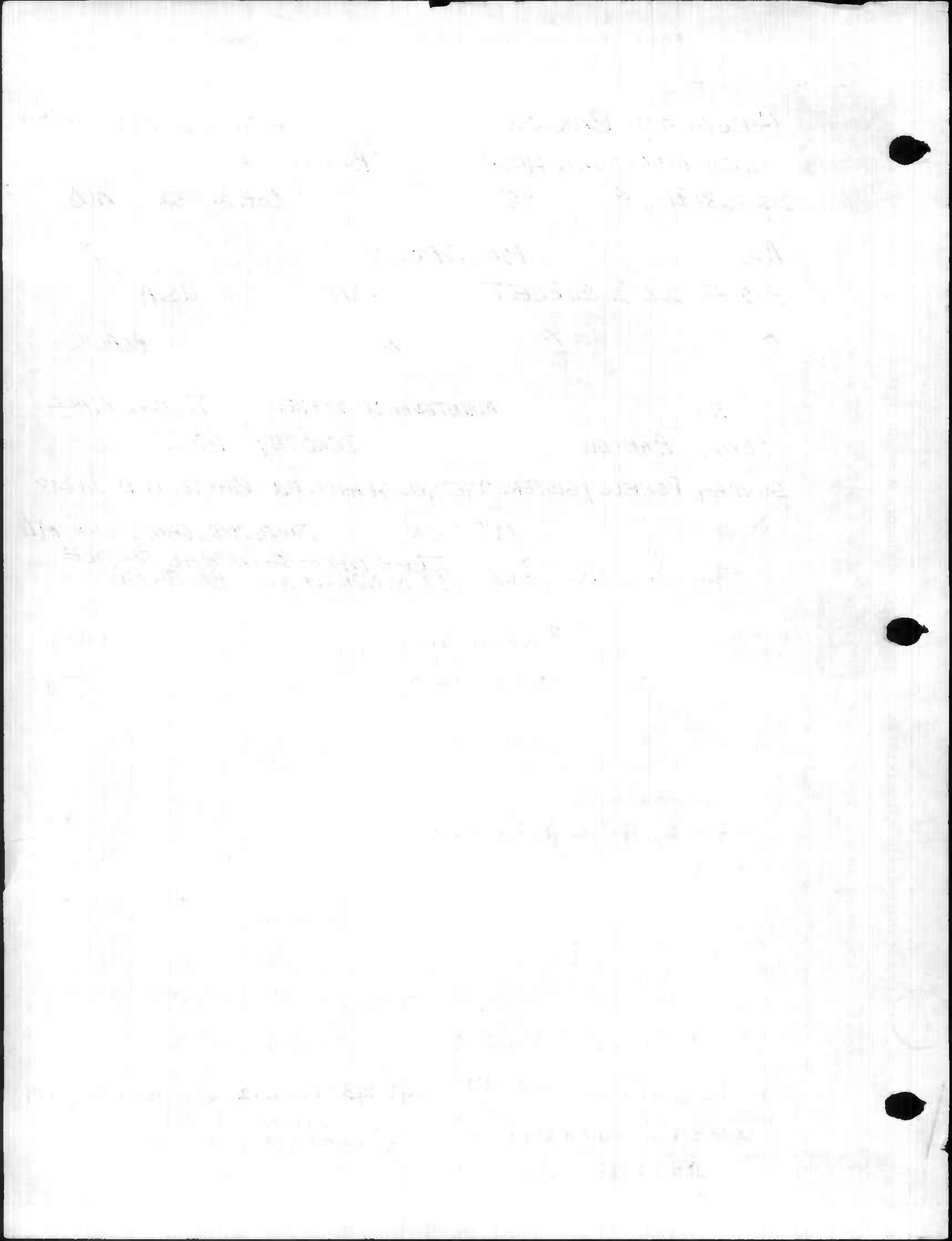
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42504

Amended Item#24a perPhyG779 1/15/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Betty Heckstall</u>				2. Date of Death Month <u>12</u> Day <u>31</u> Year <u>99</u>		3. Time of Death <u>1535</u>										
	4a. Facility Name (If not institution, give street and number) <u>Maryland Shock Trauma</u>				4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>Baltimore City</u>										
Funeral Director	5. Social Security Number <u>246-84-8771</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>49</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>6/6/50</u>	9. Birthplace (State or Foreign Country) <u>NORTH CAROLINA</u>									
	Usual Residence of Decedent																
10a. State <u>NEW YORK</u>		10b. County <u>UNKNOWN</u>		10c. City, Town or Location <u>MT VERNON</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number <u>285 7TH AVENUE</u>				10f. Zip Code <u>10550</u>		10g. Citizen of What Country? <u>USA</u>											
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7 YRS</u> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>NURSE</u>			16b. Kind of Business/Industry <u>HOSPITAL</u>										
17. Father's Name (First, Middle, Last) <u>ROBERT LEE HECKSTALL</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>MAGGIE (MNM-UNKNOWN)</u>													
19a. Informant's Name/Relationship (Type, Print) <u>YULINDA HECKSTALL (DAUGHTER)</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>285 7TH AVE., MT. VERNON NY 10550</u>													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>PETERSON CHAPEL BAPT. CHURCH</u>		20c. Location - City or Town, State <u>01-08-00 MERRY HILL, N.C.</u>											
21. Signature of Funeral Service Licensee <u>John Williams</u>				22. Name and Address of Facility <u>JOSEPH H. BROWN JR. FUNERAL HOME</u> <u>2140 N. FULTON AVE., BALTIMORE, MD. 21217</u>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td><u>Traumatic Shock</u> Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><u>Vascular rupture</u> Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td><u>Motor vehicle collision</u> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<u>Traumatic Shock</u> Due to (or as a consequence of):	b.	<u>Vascular rupture</u> Due to (or as a consequence of):	c.	<u>Motor vehicle collision</u> Due to (or as a consequence of):	d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<u>Traumatic Shock</u> Due to (or as a consequence of):															
	b.	<u>Vascular rupture</u> Due to (or as a consequence of):															
	c.	<u>Motor vehicle collision</u> Due to (or as a consequence of):															
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <u>12/24/99</u>		28b. Time of Injury <u>7:07 AM</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <u>motor vehicle collision</u> <u>MVC</u>									
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <u>Street</u>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <u>4513 Ocean Hwy</u> <u>Delmar, DE</u>													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <u>Andrew S. Verr, MD, MPH</u>				29c. License number <u>D0055095</u>		29d. Date signed (Month, Day, Year) <u>31 Dec 99</u>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Andrew S. Verr, MD, MPH 3216 St. Florio Trm Olney MD 20832</u>																	
31. Date filed (Month, Day, Year) <u>JAN 14 2000</u>				32. Registrar's Signature <u>Benjamin B. Sparks</u>													

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician
/Medical
Examiner

To the Hospital attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Benjamin B. Sparks

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item#20b perFH G779 1/18/2000 EW

Reg. No 99 42505

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lena M. McClintock

2. Date of Death

Dec 30 1999 5:25 PM

3. Time of Death

5:25 PM

4a. Facility Name (If not institution, give street and number)

Goodwill Mennonite Home

4b. City, Town, or Location of Death

Grantsville

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

170-36-4003

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/22/09

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

PA

10b. County

Somerset

10c. City, Town or Location

Confluence

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2839 Fort Hill Road

10f. Zip Code

15424

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Walter Tressler

18. Mother's Name (First, Middle, Maiden Surname)

Olive Livengood

19a. Informant's Name/Relationship (Type, Print)

Dwayne McClintock

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2804 Fort Hill Road, Confluence, PA 15424

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Addison Cemetery

Date

1/3/2000

20c. Location - City or Town, State

Addison, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Humbert Funeral Home

P. O. Box, Confluence, PA 15424

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Endstage Congestive Heart Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease
Bronchitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 34079

29d. Date signed (Month, Day, Year)

Dec 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James E. Belmont MD Grantsville MD 21536

State
Registrar

31. Date filed (Month, Day, Year)

JAN 18 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42506

Amended Item#25^{29a} perPhyG779 1/18/2000 EWPhysician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NOLA CARR RIDDER

2. Date of Death

Month Day Year

12 23 99

3. Time of Death

07:05PM

4a. Facility Name (If not Institution, give street and number)

Garrett County Memorial

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral
Director

5. Social Security Number

213-22-2602

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7-24-1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

172 Bill Roth Road

10f. Zip Code

21550

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Made Draperies

16b. Kind of Business/Industry

Upholstery

17. Father's Name (First, Middle, Last)

Paul Samuel Carr

18. Mother's Name (First, Middle, Maiden Surname)

Iva Loretta Roth

19a. Informant's Name/Relationship (Type, Print)

Paul Ridder/ son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

172 Bill Roth Rd. Oakland, Md. 21550

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Omega Crematory

Date

12/27/99 Morgantown, WV.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

D. Scott Hinkle

22. Name and Address of Facility

Hinkle Funeral Home

P.O. Box 186 Davis, WV. 26260

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure
Due to (or as a consequence of)
Fractured Hip

Approximate Interval Between Onset and Death

Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Daniel Miller

29c. License number

H 26154

29d. Date signed (Month, Day, Year)

12/24/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

69 Wolf Acres Drive Oakland MD 21550

31. Date filed (Month, Day, Year)

JAN 18 2000

32. Registrar's Signature

James B. Spotts

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at this

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

General and Special Agent

1914-1915

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#24a per PHYG779 1/15/2000 EW

Certificate of Death

Reg. No.

99 42507

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PHILLIP ROBERSON				2. Date of Death Month Day Year DECEMBER 28 1999		3. Time of Death 1:09 AM	
	4a. Facility Name (If not institution, give street and number) HARBOR HOSPITAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number unknown		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43		8. Date of Birth (Month, Day, Year) Sept 4, 1956	
	10a. State MD		10b. County Anna Arundel		10c. City, Town or Location Glen Burnie		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Usual Residence of Decedent				10f. Zip Code 21061		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) roofer		16b. Kind of Business/Industry construction		
17. Father's Name (First, Middle, Last) William Jones				18. Mother's Name (First, Middle, Maiden Surname) Willie Mae Robinson				
19a. Informant's Name/Relationship (Type, Print) Annette Stenbach/friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unknown				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Richard S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
a. PNEUMONIA Due to (or as a consequence of):				Approximate Interval Between Onset and Death 2 DAYS				
b. ACQUIRED IMMUNE DEFICIENCY SYNDROME Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Amudha Bodden MD		29c. License number AS2441614A34		
				29d. Date signed (Month, Day, Year) DECEMBER 28 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. BODDETI 6381C SMITHY SQUARE GLEN BURNIE MD 21061								
31. Date filed (Month, Day, Year) JAN 14 2000				32. Registrar's Signature Beverly B. Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42508

Amended item#23a perPhyG779 1/15/2000 EW

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Levi Stokes				2. Date of Death Month Day Year December 30, 1999				3. Time of Death 5:30pm	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death	
Funeral Director	5. Social Security Number 218-62-9923		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) December 20, 1956		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County NA		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 305 E. Belvedere		10f. Zip Code 21212		10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sanitation	
To Be Completed by Physician/Medical Examiner	16b. Kind of Business/Industry County Trash		17. Father's Name (First, Middle, Last) Sylvester Stokes		18. Mother's Name (First, Middle, Maiden Surname) Cora Lee Bryant		19a. Informant's Name/Relationship (Type, Print) Sylvia Stokes sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 E. Belvedere, Balto. MD 21212	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion		20c. Location - City or Town, State 1-4-00 Lansdowne, MD		21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Robert P. Wylie Funeral Hm PA 638 N. Belmont St. Baltimore, MD 21217	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multi-System Organ Failure from overwhelming infection Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. HIV Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier Arthur Li, medical resident	
	29c. License number RES-000		29d. Date signed (Month, Day, Year) December 30, 1999							
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital, Baltimore, MD / Arthur Li, MD									
	31. Date filed (Month, Day, Year) JAN 14 2000		32. Registrar's Signature [Signature]							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42509

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henrietta Bernice Ayers

2. Date of Death

Month Day Year
Dec. 30 99

3. Time of Death

3:00p

4a. Facility Name (If not institution, give street and number)

MALLARD BAY CENTER

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

135-24-0358

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 10, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

East New Market

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5933 Heritage Road

10f. Zip Code

21631

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Reservation Clerk

16b. Kind of Business/Industry

Commercial Airline

17. Father's Name (First, Middle, Last)

John William Ayers

18. Mother's Name (First, Middle, Maiden Surname)

Mary Thamer Higgins

19a. Informant's Name/Relationship (Type, Print)

Nancy Smith/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6677 Palmers Mill Road, Hurlock, MD 21643

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cambridge Crematory

Date

1/4/00

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21631

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Breast Carcinoma

Due to (or as a consequence of):

b. Cerebrovascular Accident

Due to (or as a consequence of):

c. Diabetes mellitus

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Year

Years

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

D50987

29d. Date signed (Month, Day, Year)

12-31-99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

AHMED NAWAZ 300 Aurora Street MD 21613

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

[Signature] B. Sparks

Cambridge

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

9003. 14 22 201

10/10/10 10/10/10

10/10/10 10/10/10

10/10/10 10/10/10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42510

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Pauline M. Adkins

2. Date of Death

Month Day Year
December 29, 1999

3. Time of Death

2:15 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

6001 Muncaster Mill Road

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

285-07-0004

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 17, 1913

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14613 Pebblestone Drive

10f. Zip Code

20905

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: White15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Operator

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

Paul Crisafulli

18. Mother's Name (First, Middle, Maiden Surname)

Carmela Lo Guidici

19a. Informant's Name/Relationship (Type, Print)

Donald M. Crisafulli/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14613 Pebblestone Drive, Silver Spring, MD 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Woodlawn Cemetery

Date

Jan 4,
2000

20c. Location - City or Town, State

Wadsworth, Ohio

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.
500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

e. Metastatic breast carcinoma

Approximate
Interval Between
Onset and Death

2 years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Casey House

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida
4 ☐ Homicide 5 ☐ Pending
investigation 6 ☐ Could not be
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Mark S. Godec, M.D.

29c. License number

D0037620

29d. Date signed (Month, Day, Year)

December 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark S. Godec M.D., Casey House, 6001 Muncaster Mill Rd., Rockville, MD 20855

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42511

Amend #7, 1/03/2000, BMW, Montg. Co.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Karen Moore Boone		2. Date of Death Month Day Year December 28, 1999		3. Time of Death 2059	
4a. Facility Name (If not institution, give street and number) Holy Cross Hospital			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery
5. Social Security Number 246-84-4333		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 50 49 Yrs.	8. Date of Birth (Month-Day, Year) Aug 5, 1949	9. Birthplace (State or Foreign Country) North Carolina
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1022C First Street			10f. Zip Code 20906		10g. Citizen of What Country? United States
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Analyst		16b. Kind of Business/Industry Cosmos, Inc.	
17. Father's Name (First, Middle, Last) Winston Moore, Jr.			18. Mother's Name (First, Middle, Maiden Surname) Effie Johnson		
19a. Informant's Name/Relationship (Type, Print) Winston Moore, Jr. Father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Turnmore Court, Silver Spring, MD 20906		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State Rockville, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Pontine Bleeding Due to (or as a consequence of):			8 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Malignant Hypertension Due to (or as a consequence of):			years
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aspiration pneumonia					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D 19971		29d. Date signed (Month, Day, Year) December 29, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kempamma Sudhakar, M.D. 7610 Carroll Ave. #230, Takoma Park, MD 20912					
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature 			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42512

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Ann Bickel

2. Date of Death

December 29, 1999

3. Time of Death

9:27 am

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

216-58-9045

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 23, 1951

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

609 Ivy League Lane

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Charles D. Bickel

18. Mother's Name (First, Middle, Maiden Surname)

Mary Matassa

19a. Informant's Name/Relationship (Type, Print)

Charles D. Bickel/ Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3814 Denfield Ave., Kensington, MD 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Jan 3
2000

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Robert E. Ramsey

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiac Arrest

Due to (or as a consequence of):

3 hrs

b. Seizure

Due to (or as a consequence of):

3 hrs

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Seizure Disorder, failure to take medicine

Due to (or as a consequence of):

24 hrs

d. Birth Defect

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Eric Greenberg

29c. License number

D 50275

29d. Date signed (Month, Day, Year)

December 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric Greenberg, MD 11125 Rockville Pike, Rockville, MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

Anna B. Sparks

Baltimore, Maryland 21215-0020

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42513

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ray Bickerton

2. Date of Death

Month

Day

Year

December 21, 1999

3. Time of Death

7¹⁰ PM

4a. Facility Name (If not institution, give street and number)

ROCKGLEN NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

577-60-4004

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 13, 1908

9. Birthplace (State or Foreign Country)

Washington, DC.

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4501 44th St. NW.

10f. Zip Code

20016

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

PURCHASER

16b. Kind of Business/Industry

U.S. GOVERNMENT

17. Father's Name (First, Middle, Last)

GEORGE GILPIN DUVAL

18. Mother's Name (First, Middle, Maiden Surname)

MARY REBECCA MCGINNIS

19a. Informant's Name/Relationship (Type, Print)

GEORGE BICKERTON - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4680 Morgan Ct., Ellicott City, Md. 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

PARKLAWN MEMORIAL PARK 12/27/99 Rockville, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.

5130 Wisc. Ave. NW., Wash. DC. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

e. Dementia, Alzheimer's Type

Due to (or as a consequence of):

6y

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N/A

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accidental3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

N/A

28b. Time of

Injury

N/A

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

N/A

28d. Describe how injury occurred

N/A

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

N/A

29a. Certifier

(Check only

one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29b. Signature and title of certifier

29c. License number

D43386

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Howard, Md. 821 N. Eutaw St. #405, Baltimore, Md. 21201

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42511

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELLA LEE BRYAN				2. Date of Death Month Day Year DECEMBER 29, 1999				3. Time of Death 3:10 PM	
	4a. Facility Name (If not institution, give street and number) 1610 GOLD MINE ROAD				4b. City, Town, or Location of Death BROOKEVILLE				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 577 16 6852		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 11, 1917		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 806 SNIDER LANE				10f. Zip Code 20905		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) JAMES HERBERT JOHNSON SR.				18. Mother's Name (First, Middle, Maiden Surname) CARRIE EDWARDS					
	19a. Informant's Name/Relationship (Type, Print) H. ARDELL HOWES, DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1610 GOLD MINE ROAD, BROOKEVILLE, MD. 20833					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BURTONSVILLE UNION CEM.		20c. Location - City or Town, State 1/4/00 BURTONSVILLE, MD.					
	21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC NON SMALL CELL LUNG CANCER (approx 6 months) Due to (or as a consequence of): b. Deep vein thrombosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) DAUGHTER'S HOME					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier Joseph Kaplan MD				29c. License number D35635		29d. Date signed (Month, Day, Year) DECEMBER 30, 1999			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH KAPLAN, M.D., 18111 PRINCE PHILIP DR. SUITE 327, OLNEY, MD. 20832									
	31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42515

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Rebecca Coblenz

2. Date of Death

Month Day Year
Dec 30th 1999

3. Time of Death

6:45 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

042-07-5973

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

February 6, 1916 New York

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6121 Montrose Road

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Benjamin Tauber

18. Mother's Name (First, Middle, Maiden Surname)

Mary Freedhand

19a. Informant's Name/Relationship (Type, Print)

Robert Coblenz Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8005 Treasure Tree Court, Springfield, VA 22153

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wellwood Cemetery

Date

1/3/00

20c. Location - City or Town, State

Pinelawn, NY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street, Alexandria, VA 22310

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute cardiopulmonary arrest

Due to (or as a consequence of):

b. coronary artery disease

Due to (or as a consequence of):

c. uro sepsis

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

osteoporosis Rheumatoid Arthritis

Pernicious Anemia allergy: Novozaine

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D: 44907

29d. Date signed (Month, Day, Year)

Dec 31st 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 Montrose Road, Rockville, MD 20815

Consue to M... 20815

31. Date filed (Month, Day, Year)

JAN 06 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Coblenz, Rebecca
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42516

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Esther H. Clem

2. Date of Death

Month Day Year
December 31, 1999

3. Time of Death

2:07 am

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Forest Glen Skilled Nursing Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

139-16-2907

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct 23, 1918

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6715 Munsey Street

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Ira Patrick Hayes

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Oheith

19a. Informant's Name/Relationship (Type, Print)

W. Allen Clem, III

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6715 Munsey Street, Hyattsville, MD 20784

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

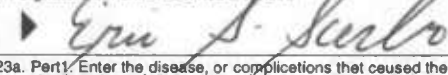
20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 01/01/2000 Alexandria, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd. West, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ruth Kevers-Cohen M.D.

29c. License number

D33159

29d. Date signed (Month, Day, Year)

December 31, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ruth Kevers-Cohen M.D. 8700 Georgia Ave #400 Silver Spring MD 20910

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-588-0258.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-588-0258.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42517

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henrietta A. Cannella				2. Date of Death Month Day Year December 30, 1999		3. Time of Death 3:32 PM	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 076-18-3682		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 2, 1912	
	9. Birthplace (State or Foreign Country) Maryland		10a. State		10b. County		10c. City, Town or Location	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 4201 Butterworth Place, NW #415		10f. Zip Code 20016		
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Switchboard Operator		16b. Kind of Business/Industry Insurance		
17. Father's Name (First, Middle, Last) Charles H. Maddox				18. Mother's Name (First, Middle, Maiden Surname) Esther Lusby				
19a. Informant's Name/Relationship (Type, Print) Allen H. Cannon (nephew)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1131 University Blvd., W. Penthouse #1 Silver Spring, Maryland 20902				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland		20d. Date Jan. 3, 2000		
21. Signature of Funeral Service Licensee J. L. Chapple				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARRHYTHMIA								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier J. L. Chapple				29c. License number 042518		29d. Date signed (Month, Day, Year) Dec 30, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Chapple, 1119 Rockville Pike #401, Rockville, MD 20852								
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

DANITZA I. CAMPOS

2. Date of Death

Month Day Year
DECEMBER 25 1999

3. Time of Death

3:25 A

4a. Facility Name (If not institution, give street and number)

HIGHLAND RD. & CLARKSVILLE

4b. City, Town, or Location of Death

CLARKSVILLE

4c. County of Death

HOWARD

Funeral
Director

5. Social Security Number

518-25-4787

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

27 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN. 23, 1972

9. Birthplace (State or Foreign Country)

MEXICO

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

LAUREL

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

11611 CLOCK TOWER LANE

10f. Zip Code

20708

10g. Citizen of What Country?

MEXICO

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify: MEXICAN14. Race - American Indian,
Black, White, etc.

Specify: HISPANIC

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

ADMINISTRATIVE ASSISTANT

16b. Kind of Business/Industry

RETAIL ELECTRONICS

17. Father's Name (First, Middle, Last)

JOSE CAMPOS

18. Mother's Name (First, Middle, Maiden Surname)

ADLY CASTREJON

19a. Informant's Name/Relationship (Type, Print)

ADLY E. CAMPOS/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11611 CLOCK TOWER LANE LAUREL, MD 20708

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

CHESAPEAKE CREMATORY

Date

12/30/99

20c. Location - City or Town, State

BELTSVILLE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Multiple injuries
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation 6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)

12/25/99

28b. Time of
Injury

3:00 AM

28c. Injury at
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Substitution of vehicle that hit
roadway28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State) High Land Road
Clarksville Maryland29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

DECEMBER 25, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODOR M. Keig

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42519

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Dewey B. Crawford

2. Date of Death
Month Day Year
December 29, 19993. Time of Death
4:07 PM

4a. Facility Name (If not institution, give street and number)

9720 Woodland Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director5. Social Security Number
439-09-81586. Sex
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)
91 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
Sep 10, 19089. Birthplace (State or Foreign
Country)
Louisiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9720 Woodland Drive

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1942-
194513. Was Decedent of Hispanic Origin? (Specify Yes or No.
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

General Trucking

17. Father's Name (First, Middle, Last)

Silas Crawford

18. Mother's Name (First, Middle, Maiden Surname)

Julie Gray

19a. Informant's Name/Relationship (Type, Print)

Alfra T. Crawford/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9720 Woodland Drive, Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

1/3/00

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

J. Keir Skiles

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. *Ventricular tachycardia*
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Lastb. *Atherosclerosis*
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*atrial fibrillation**Peripheral vascular disease**Hypertension*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward J. Richards M.D.

29c. License number

D-12703

29d. Date signed (Month, Day, Year)

12-30-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward J. Richards, M.D. 10301 Georgia Ave., #203, Silver Spring, MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42520

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA COOPER

2. Date of Death

Month
12Day
21Year
99

3. Time of Death

1728

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

6-9-33

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

Worcester

10c. City, Town or Location

Pocomoke

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1973 Colona Road

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Line - worker

16b. Kind of Business/Industry

Poultry

17. Father's Name (First, Middle, Last)

Richard Reynolds

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Brittingham

19a. Informant's Name/Relationship (Type, Print)

James Cooper (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1973 Colona Rd. Pocomoke md. 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. James Cemetery

Date

12-26-99 Pocomoke City, md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home
P.O. Box 331 Pocomoke City, md. 2185123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and Death

e. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0003599

29d. Date signed (Month, Day, Year)

12-22-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D.

106 MILFORD STREET

SALISBURY, MARYLAND

21804

31. Date filed (Month, Day, Year)

DEC 29 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42521

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Inez Dabney

2. Date of Death

Month Day Year
December 26, 1999

3. Time of Death

3:30 PM

4a. Facility Name (If not institution, give street and number)

Fox Chase Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-01-6362

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 15, 1905

9. Birthplace (State or Foreign Country)

Mississippi

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4727 Eads Street, N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Pentagon

17. Father's Name (First, Middle, Last)

Ambrose Shief

18. Mother's Name (First, Middle, Maiden Surname)

Rebecca Salvand

19a. Informant's Name/Relationship (Type, Print)

William G. Dansie conservator

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

601 Indiana Ave. N.W., #814, Washington, D.C. 20004

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lincoln Memorial

Date

12/30/99

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

Andre Thompson

22. Name and Address of Facility

McGuire Funeral Service, Inc.

7400 Georgia Ave. N.W., Washington, D.C. 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Aspiration Pneumonia

Due to (or as a consequence of):

72 hrs.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Alan R. Segal, M.D.

29c. License number

D52261

29d. Date signed (Month, Day, Year)

December 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan R. Segal, M.D. 1299 Lamberton Drive, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

Anna B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 99 42522
Certificate of Death Reg. No.

Reg. No.

1. Decedent's Name (First, Middle, Last)
Ann Mumford Dickinson

2. Date of Death
Month Day Year
Dec. 27, 1999

3. Time of Death
6:00 PM

4a. Facility Name (If not institution, give street and number)
Carriage Hill

4b. City, Town, or Location of Death
Bethesda

4c. County of Death
Montgomery

5. Social Security Number
043-38-6801

6. Sex
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)
86 Yrs.

8. Date of Birth (Month, Day, Year)
Nov. 23, 1913

9. Birthplace (State or Foreign Country)
New Jersey

10a. State
Maryland

10b. County
Montgomery

10c. City, Town or Location
Bethesda

10d. Inside City Limits
1 ☒ Yes 2 ☐ No

10e. Street and Number
4906 Jamestown Rd.

10f. Zip Code
20816

10g. Citizen of What Country?
USA

11. Marital Status
1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) College (1-4 or 5+)
2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
Home Maker

16b. Kind of Business/Industry
Own Home

17. Father's Name (First, Middle, Last)
Norman Winthrop Mumford

18. Mother's Name (First, Middle, Maiden Surname)
Harriet Oliver

19a. Informant's Name/Relationship (Type, Print)
Lucinda D. Conger/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4906 Jamestown Rd. Bethesda, MD 20816

20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory

20c. Location - City or Town, State
Alex., VA

20d. Date
Dec. 31, 99

21. Signature of Funeral Service Licensee
James E. B. B. B.

22. Name and Address of Facility
DeVol Funeral Home
2222 Wisconsin Ave., N.W.
Washington, D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

b. Stroke
Due to (or as a consequence of):

c. Aspiration
Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury
M

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier
James J. Foster

29c. License number
D0004179

29d. Date signed (Month, Day, Year)
December 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
James J. Foster, 5530 Wisconsin Ave., Chevy Chase, Md. 20815

31. Date filed (Month, Day, Year)
JAN 05 2000

32. Registrar's Signature
B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42523

Certificate of Death

Reg. No.

Amend #2, 1/3/2000, BMW, Montg. Co.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louis Nicholas Dyer				2. Date of Death Month December Day 26 Year 1999		3. Time of Death 09:46 AM	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number NA	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) - Yrs.	If Under 1 Year Months 5 Days 5	If Under 24 Hrs. Hours 5 Min.	8. Date of Birth (Month, Day, Year) Dec. 21, 1999		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg			10d. Inside City Limits 1 Yes 2 No	
10e. Street and Number 6413 Sweet Meadow Court				10f. Zip Code 20882		10g. Citizen of What Country? United States		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NA		16b. Kind of Business/Industry NA		
17. Father's Name (First, Middle, Last) Louis J. Dyer				18. Mother's Name (First, Middle, Maiden Surname) Tracey Jenkins				
19a. Informant's Name/Relationship (Type, Print) Louis J. Dyer / Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6413 Sweet Meadow Court, Gaithersburg, Md. 20882				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 12/30/99		20c. Location - City or Town, State Silver Spring, Md.		
21. Signature of Funeral Service Licensee K Roy W. Baker				22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Hypertension Due to (or as a consequence of): b. Extreme Intra Uterine Growth Retardation Due to (or as a consequence of): c. Extreme low birth weight Due to (or as a consequence of): d. Prematurity								Approximate Interval Between Onset and Death 2 days 5 days 5 days 5 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
								24a. Was an autopsy performed? 1 Yes 2 No
								24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Maddurigan MD				29c. License number D 43225		29d. Date signed (Month, Day, Year) December, 26, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHUR NIGAM MD Shady Grove Adventist Hospital, Rockville, MD 20850								
State Registrar		31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

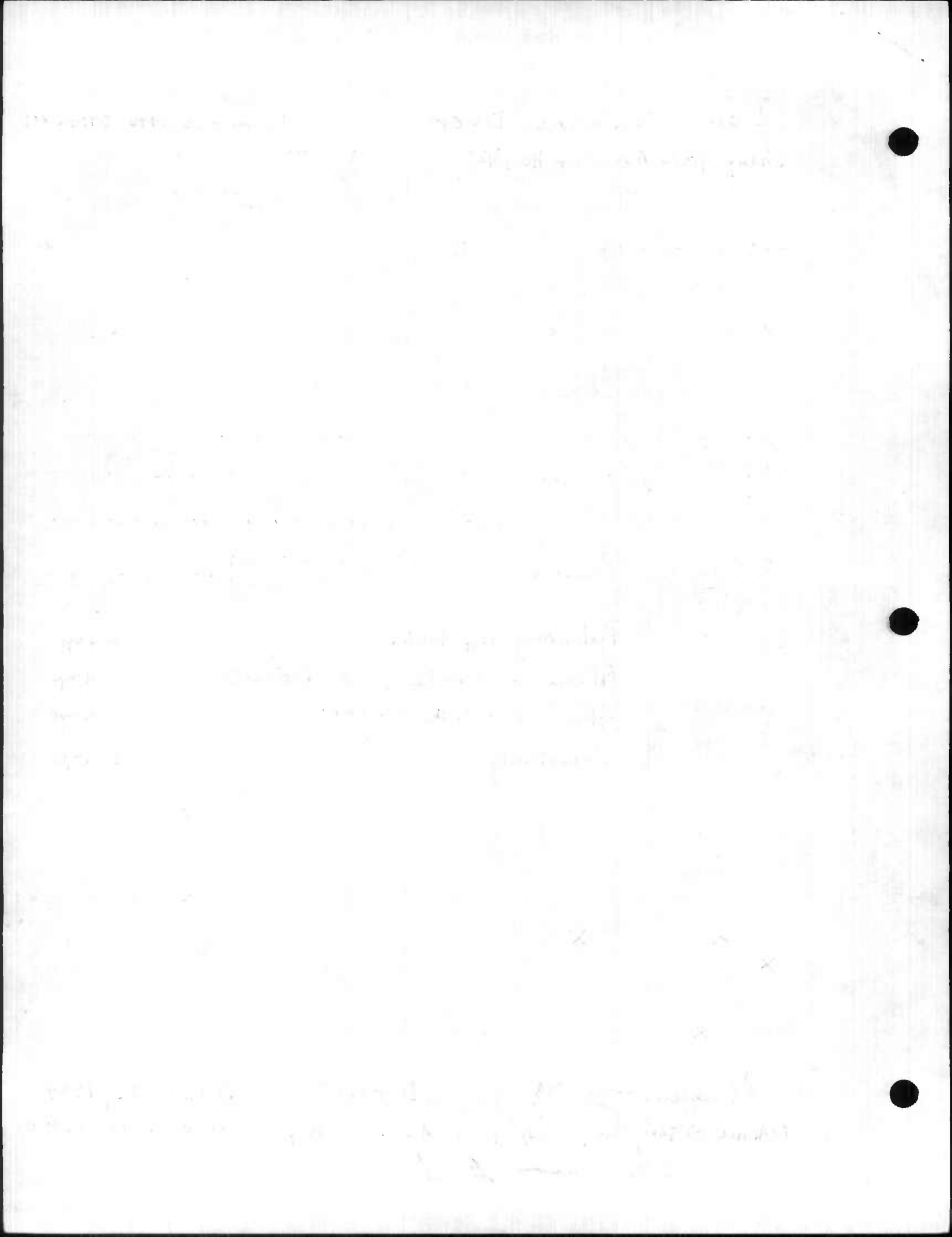
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42524

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Agnes V. Feury				2. Date of Death Month Day Year December 29, 1999		3. Time of Death 3:30 PM	
	4a. Facility Name (If not institution, give street and number) Potomac Valley Nursing Home				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 084-05-1329		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) June 23, 1909	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4830 Montgomery Lane		10f. Zip Code 20814		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Underwriter		16b. Kind of Business/Industry Insurance			
	17. Father's Name (First, Middle, Last) John Edward Feury				18. Mother's Name (First, Middle, Maiden Surname) Mary T. McGonegal			
	19a. Informant's Name/Relationship (Type, Print) Regina T. Richards/Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4830 Montgomery Lane, Bethesda, Maryland 20814			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Hawthorne, New York		20d. Date Jan. 4, 2000	
	21. Signature of Funeral Service Licensee  M00198				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Dehydration Due to (or as a consequence of): c. Electrolyte Imbalance Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 10 				29c. License number D35791		29d. Date signed (Month, Day, Year) December 30, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merlyn K. Vemury, M.D. 9801 Georgia Avenue, Silver Spring, Maryland 20902							
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature 				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42525

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Cora Friedlis</u>				2. Date of Death Month <u>November</u> Day <u>19</u> Year <u>1999</u>		3. Time of Death <u>4:00 am</u>		
	4a. Facility Name (If not institution, give street and number) <u>9500 Last Trail Way</u>				4b. City, Town, or Location of Death <u>Potomac</u>		4c. County of Death <u>Montgomery</u>		
Funeral Director	5. Social Security Number <u>364-12-4605</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>84</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>February 4, 1915</u>		
	9. Birthplace (State or Foreign Country) <u>Louisiana</u>		10a. State <u>CA</u>		10b. County <u>San Diego</u>		10c. City, Town or Location <u>Solano Beach</u>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>805 Valley Avenue Apt. 230</u>		10f. Zip Code <u>92075</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Sales</u>		16b. Kind of Business/Industry <u>Retail</u>		17. Father's Name (First, Middle, Last) <u>Albert Landry</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Emma Piegean</u>	
19a. Informant's Name/Relationship (Type, Print) <u>J. Andre Friedlis / Son</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1186 Chartwell N. East Lansing MI 48823</u>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Anatomic Gift Foundation</u>		20c. Date <u>11/19/1999</u>		20d. Location - City or Town, State <u>Laural, Maryland</u>			
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>Anatomic Gift Foundation</u> <u>13948 Baltimore Avenue Level MD 20707</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Metastatic Breast Carcinoma</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Due to (or as a consequence of):</u> <u>Due to (or as a consequence of):</u> <u>Due to (or as a consequence of):</u>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>Sons Resident</u>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u> M.D.		29c. License number <u>0101022194</u>		29d. Date signed (Month, Day, Year) <u>1/12/00</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>WINSTON H. UENO M.D.</u> <u>1500 N. BRIDGE RD ST. 103 Alex. Va. 22311</u>		31. Date filed (Month, Day, Year) <u>JAN 14 2000</u>		32. Registrar's Signature <u>[Signature]</u>					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42526

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William R. Gallion

2. Date of Death

Month Day Year
Dec. 9, 1999

3. Time of Death

11:40 AM

4a. Facility Name (If not institution, give street and number)

5314 Blackistone Road

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

N/A

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

1

12

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 27, 1999

9. Birthplace (State or Foreign Country)

Washington, DC.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5314 Blackistone Road

10f. Zip Code

20816

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Tad Gallion

18. Mother's Name (First, Middle, Maiden Surname)

Kristen Schaefer

19a. Informant's Name/Relationship (Type, Print)

Kristen Schaefer - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5314 Blackistone Road, Bethesda, Md. 20816

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Crematory

Date

12/17/99

20c. Location - City or Town, State

Falls Church, Va.

21. Signature of Funeral Service Licensee

Thomas E. Hambrook

22. Name and Address of Facility

Joseph Gawler's Sons, Inc.
5130 Wisc. Ave. NW., Washington, DC. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardiorespiratory Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 - 2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Apnea and Bradycardia

Due to (or as a consequence of):

3 Weeks

c. Severe Gastro Esophageal Reflux

Due to (or as a consequence of):

4 Weeks

d. Undetermined Chromosomal Defect

5 Weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Abnormal MRI of the Brain, Hypotonia

Atrial Septal Defect

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Howard Bennett, MD.

29c. License number

DC12072

29d. Date signed (Month, Day, Year)

12/27/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Bennett, MD. 5225 Connecticut Ave. NW. Washington, DC. 20015

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42527

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIE CECILIA GORMAN

2. Date of Death

Month Day Year
DEC 28 1999

3. Time of Death

9:58 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

547-80-8034

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
July 9, 1914

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

College Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5207 Paducah Road

10f. Zip Code

20740

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

William Mitchell Hayden

18. Mother's Name (First, Middle, Maiden Surname)

Sarah E. Payne

19a. Informant's Name/Relationship (Type, Print)

Mary V. Divver (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 1609 Prince Frederick, Maryland 20678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery 1/4/2000 Arlington, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. APNEA

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Eric F. Wedam MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

29 DEC 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERICH F. WEDAM, LT, MC, USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

State
Registrar

31. Date filed (Month, Day, Year)

JAN 06 2000

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42528

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Marie Gleber

2. Date of Death

Dec. 18, 1999

3. Time of Death

5:30AM

4a. Facility Name (If not institution, give street and number)

Manor Care-Potomac

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

053-52-6970

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 6, 1902

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5324 Albermarle St.

10f. Zip Code

20816

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Schaefer Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Eva Unknown

19a. Informant's Name/Relationship (Type, Print)

Marilyn Wagner-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5324 Albermarle St., Bethesda, MD 20816

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

National Crematory

Date

12/22/99 Falls Church, VA

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons INC, 5130 Wisconsin Ave.
NW, Washington, DC 20016Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

Anemia

3 Days

a. Due to (or as a consequence of):

Lower Gastrointestinal Bleed

2 Weeks

b. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D0038781

29d. Date signed (Month, Day, Year)

12/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael J. Grady, MD 4910 Massachusetts Ave. NW Washington, DC 20016

State
Registrar

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 42529

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOE LEE GILMORE				2. Date of Death Month Day Year DECEMBER 29, 1999		3. Time of Death 6:25 P.M.	
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 374-38-5659		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JULY 17, 1939	9. Birthplace (State or Foreign Country) MISSISSIPPI
	Usual Residence of Decedent							
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 2612 VILLAGE LANE				10f. Zip Code 20906		10g. Citizen of What Country? UNITED STATES OF AMERICA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CONSULTANT		16b. Kind of Business/Industry U.S. GOVERNMENT/ PRIVATE SECTOR		
17. Father's Name (First, Middle, Last) LEE RUSSELL GILMORE					18. Mother's Name (First, Middle, Maiden Surname) JESSIE ANNIE BROWN			
19a. Informant's Name/Relationship (Type, Print) BARBARA E. GILMORE/SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2612 VILLAGE LANE SILVER SPRING, MARYLAND 20906				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) EVERLY CREMATORY		20c. Location - City or Town, State 1/5/2000 FAIRFAX, VA		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ImmEDIATE Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 day
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STROKE DIABETES SARCOIDOSIS						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number D 21340		29d. Date signed (Month, Day, Year) DECEMBER 30, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND BASS 3941 FERRARA DRIVE WHEATON, MD 20906								
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

James M. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42530

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) DAISY M. GILLESPIE				2. Date of Death Month DEC. Day 29 , Year 1999		3. Time of Death 1410	
4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death MONTGOMERY	
5. Social Security Number 419-32-1619		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 28, 1922	
9. Birthplace (State or Foreign Country) Georgia		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2017 Hopefield Road		10f. Zip Code 20905		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service Worker		16b. Kind of Business/Industry P.G. County Board of Ed.		17. Father's Name (First, Middle, Last) John Mitchell	
18. Mother's Name (First, Middle, Maiden Surname) Daisy Daniels		19a. Informant's Name/Relationship (Type, Print) Mary McCurty (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2017 Hopefield Rd., Silver Spring, MD 20905		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Washington Cem.		20c. Location - City or Town, State Adelphi, MD		21. Signature of Funeral Service Licensee <i>George R. Snowden</i>		22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ischemic Cardiomyopathy Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 10 years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL FAILURE		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and Title of certifier <i>James B. Bass MD</i>		29c. License number D21340		29d. Date signed (Month, Day, Year) December 29, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND BASS 3941 FERRARA DR. WHEATON, MD 20906	
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature <i>James B. Bass</i>		State Registrar		DHHM 16 Rev 6/95	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42531

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert Jackson Guynn, Sr.						2. Date of Death Month December Day 31 , Year 1999		3. Time of Death 8:07P.		
	4a. Facility Name (If not institution, give street and number) 11709 Roby Avenue						4b. City, Town, or Location of Death Beltsville		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 230-34-0290		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 12, 1927		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Beltsville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 11709 Roby Avenue				10f. Zip Code 20705		10g. Citizen of What Country? United States					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dry wall hanger			16b. Kind of Business/Industry construction				
17. Father's Name (First, Middle, Last) Ellis Jackson Guynn						18. Mother's Name (First, Middle, Maiden Surname) Laura McMillian					
19a. Informant's Name/Relationship (Type, Print) Ralph M. Guynn (son)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10227 Riggs Rd. Adelphi, Maryland 20783					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) George Washington Cemetery			20c. Location - City or Town, State 1/5/2000 Adelphi, Maryland					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. METASTATIC ADENOCARCINOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death MONTHS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SUSPECTED PRIMARY PANCREAS								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number D 24035		29d. Date signed (Month, Day, Year) 1/4/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. MACHADO 321 PRINCE GEORGE ST LAUREL MD 20723											
State Registrar		31. Date filed (Month, Day, Year) JAN 06 2000		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42532

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Odessa Hall

2. Date of Death

December 30, 1999

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

4619 Raleigh Road

4b. City, Town, or Location of Death

Temple Hills

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

246-96-3067

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 9, 1933

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

N.C.

10b. County

Chowan

10c. City, Town or Location

Edenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1004 B Hall Lane

10f. Zip Code

27932

10g. Citizen of What Country?

USA

11. Marital Status

X ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Lodging

17. Father's Name (First, Middle, Last)

Harvey Hall

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Riddick

19a. Informant's Name/Relationship (Type, Print)

Mary Williams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4619 Raleigh Road Temple Hills, MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Center Hill Chapel Cem. 01/05/00 Tyner, North Carolina

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, VA 22310

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Endometrial Cancer

Due to (or as a consequence of):

b. Metastasis to Lung and Liver

Due to (or as a consequence of):

c. Respiratory Arrest

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0029142

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles Boice, MD

10301 Georgia Avenue Silver Spring, MD

State
Registrar

31. Date filed (Month, Day, Year)

JAN 06 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-388-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42533

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Alice Harris</i>				2. Date of Death Month <i>12</i> Day <i>28</i> Year <i>99</i>		3. Time of Death <i>5:00 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Manor Care</i>				4b. City, Town, or Location of Death <i>Silver Spring</i>		4c. County of Death <i>Montgomery</i>	
Funeral Director	5. Social Security Number <i>577-62-1124</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>99</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>Jan 2, 1900</i>	
	9. Birthplace (State or Foreign Country) <i>Washington, D.C.</i>							
Usual Residence of Decedent								
10a. State <i>Maryland</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Silver Spring</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>2501 Musgrove Road</i>				10f. Zip Code <i>20904</i>		10g. Citizen of What Country? <i>United States</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Housewife</i>			16b. Kind of Business/Industry <i>Home</i>	
17. Father's Name (First, Middle, Last) <i>William Meyers</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Jennie Townsend</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Juanita W. Harris Daughter in law</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3003 Van Ness Street, N.W. S-502 Washington, D.C.</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Arlington National Cemetery</i>		20c. Location - City or Town, State <i>Arlington, VA</i>		
21. Signature of Funeral Service Licensee <i>Thomas A. Alburn</i>				22. Name and Address of Facility <i>McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) <i>a. PNEUMONIA</i> Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>								Approximate Interval Between Onset and Death <i>1 week</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Organic Brain Syndrome, Hypertension Consecutive heart failure</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Dying Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Dr. Maglio</i>		29c. License number <i>025430</i>		29d. Date signed (Month, Day, Year) <i>12/29/99</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>John MARGOLIS 13952 Baltimore Ave Laurel MD 20707</i>								
31. Date filed (Month, Day, Year) <i>JAN 03 2000</i>		32. Registrar's Signature <i>B. Adams</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42534

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) JOHN T. HAWKINS		2. Date of Death Month Dec Day 31 Year 1999		3. Time of Death 4 PM	
4a. Facility Name (If not institution, give street and number) Brooke Grove Nursing Home			4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery
5. Social Security Number 163-05-9366		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) Oct 17, 1912		9. Birthplace (State or Foreign Country) Virginia			

Funeral
Director

To Be Completed by Funeral Director

10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 414 Burnt Mills Avenue			10f. Zip Code 20901		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager/ Owner		16b. Kind of Business/Industry Service Station			
17. Father's Name (First, Middle, Last) Joseph C. Hawkins				18. Mother's Name (First, Middle, Maiden Surname) Lena Fitzhugh			
19a. Informant's Name/Relationship (Type, Print) Eileen Eshleman / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17415 Applewood Lane, Derwood, MD 20855			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date Jan 5 2000		20c. Location - City or Town, State Silver Spring, MD	
21. Signature of Funeral Service Licensee James S. Dooly				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901			

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Apoptosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death Auto	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Thomas E. Dooly, MD		29c. License number P16458		29d. Date signed (Month, Day, Year) Dec 31, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas E. Dooly, MD 17082092 Ave. Chevy, MD 20831					
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature B. Sparks			

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #8 PER F.H. G779

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 42535

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Harry W. Henderson</u>				2. Date of Death Month <u>December</u> Day <u>28</u> Year <u>1999</u>		3. Time of Death <u>9:30 am</u>	
	4a. Facility Name (If not institution, give street and number) <u>3502 Fitzhugh Lane</u>				4b. City, Town, or Location of Death <u>Silver Spring</u>		4c. County of Death <u>Montgomery</u>	
Funeral Director	5. Social Security Number <u>577-60-1665</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>91</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Nov 14, 1908</u>	
	9. Birthplace (State or Foreign Country) <u>Indiana IOWA</u>		10a. State <u>Maryland</u>		10b. County <u>Montgomery</u>		10c. City, Town or Location <u>Silver Spring</u>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <u>3502 Fitzhugh Lane</u>		10f. Zip Code <u>20906</u>		10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <u>1944-1946</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4</u> College (14 or 5+) <u>4</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Writer</u>		16b. Kind of Business/Industry <u>Department of Agriculture</u>			
	17. Father's Name (First, Middle, Last) <u>Curtis Alonzo Henderson</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Nora Blanche McClure</u>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Eleanor R. Henderson/ Wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3502 Fitzhugh Lane, Silver Spring, MD 20906</u>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Parklawn Memorial Park</u>		20c. Location - City or Town, State <u>2000 Rockville, MD</u>		20d. Date <u>Jan 5</u>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>James S. Doherty</u>				22. Name and Address of Facility <u>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>a. Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>b. Due to (or as a consequence of):</u> <u>c. Due to (or as a consequence of):</u> <u>d. Due to (or as a consequence of):</u>				Approximate interval between Onset and Death <u>1 year</u>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Abdominal Aortic Aneurysm</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <u>James A. Rossi MD</u>			
	29c. License number <u>D 24543</u>				29d. Date signed (Month, Day, Year) <u>December 28, 1999</u>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>James A. Rossi, MD 3305 North Leisure World Blvd., Silver Spring, MD 20906</u>				31. Date filed (Month, Day, Year) <u>JAN 03 2000</u>			
	32. Registrar's Signature <u>James B. Sparks</u>				33. Registrar's Signature <u>James B. Sparks</u>			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

2541

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42536

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JENNIE V. HITCHCOCK

2. Date of Death

Month Day Year
DECEMBER 25, 1999

3. Time of Death

3:43AM

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

032-12-7811

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MAY 8, 1919

9. Birthplace (State or Foreign Country)

MASSACHUSETTS

Usual Residence of Decedent

10a. State

MARYLAND PRINCE GEORGES

10b. County

10c. City, Town or Location

LANGLEY PARK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1706 LANGLEY WAY

10f. Zip Code

20783

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

LORETO ABITABILE

18. Mother's Name (First, Middle, Maiden Surname)

ANNA DINNUCCI

19a. Informant's Name/Relationship (Type, Print)

RICHARD HITCHCOCK/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1706 LANGLEY WAY LANGLEY PARK, MD 20783

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

12/31/99

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI FUNERAL HOME, INC.

11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. CARCINOMA LUNG

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Deep vein Thrombosis

Stage IV sacral decubitus

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01852

29d. Date signed (Month, Day, Year)

DECEMBER 28/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL A. DEVORE, MD 4003 QUEENSBURY RD Hyattsville MD 20781

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42537

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CLAIRE ANN KENNEY				2. Date of Death Month Day Year DEC 29 1999		3. Time of Death 9:45 AM			
	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				4b. City, Town, or Location of Death BETHESDA		4c. County of Death MONTGOMERY			
Funeral Director	5. Social Security Number 018-24-9796		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) DEC. 13, 1930	9. Birthplace (State or Foreign Country) MASSACHUSETTS		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State VA		10b. County FAIRFAX		10c. City, Town or Location FAIRFAX			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 6020 BERWYND ROAD				10f. Zip Code 22030		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER			16b. Kind of Business/Industry EDUCATION		
	17. Father's Name (First, Middle, Last) ZEPHYR BROUILLARD				18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE DEELEY					
	19a. Informant's Name/Relationship (Type, Print) WILLIAM J. KENNEY (SPOUSE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6020 BERWYND RD. FAIRFAX, VIRGINIA 22030					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. MICHAEL CEMETERY		Data JAN. 5, 2000		20c. Location - City or Town, State SPRINGFIELD, MA			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EVERLY FUNERAL HOME 10565 MAIN STREET FAIRFAX, VIRGINIA 22030					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA Due to (or as a consequence of): SEPSIS Due to (or as a consequence of): PROGRESSIVE SUPRANUCLEAR PALSY Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  M.D.		29c. License number 8294 (MT)		29d. Date signed (Month, Day, Year) Dec 30, 1999				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) J. A. TJAREN, LT, MC, USN				NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600						
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42538

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SIDNEY ALEXANDER KLINE				2. Date of Death Month 12 Day 31 Year 99		3. Time of Death 9:40AM	
	4a. Facility Name (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 577.48.2250		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 6.12.1914	
	9. Birthplace (State or Foreign Country) WASHINGTON, DC		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 6121 MONTROSE ROAD		10f. Zip Code 20852	
	10g. Citizen of What Country? USA				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SELF EMPLOYED				16b. Kind of Business/Industry PUBLISHING DISTRIBUTION			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) NATHAN KLINE				18. Mother's Name (First, Middle, Maiden Surname) RAE SHULKIN			
	19a. Informant's Name/Relationship (Type, Print) CALVIN KLINE/SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9213 BENT RIDGE AVE, POTOMAC, MARYLAND 20854			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. anorexia Due to (or as a consequence of): c. dementia Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death 2 weeks 6 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 	
	29c. License number D34969						29d. Date signed (Month, Day, Year) December 31, 1999	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) H. Victor Chiang MD, 9707 Medical Center Dr. suite 320, Rockville 20850						31. Date filed (Month, Day, Year) JAN 05 2000	
	32. Registrar's Signature 						33. Registrar's Title Registrar	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42539

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVELYN FRANCES MILLER				2. Date of Death Month Day Year DECEMBER 31, 1999		3. Time of Death 12:01 A.M.	
	4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL				4b. City, Town, or Location of Death OLNEY		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 059-16-5928		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) APR. 13, 1919	
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location OLNEY	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3617 PATRICK HENRY DRIVE		10f. Zip Code 20832		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOME			
	17. Father's Name (First, Middle, Last) C. RAYMOND BLANCHARD				18. Mother's Name (First, Middle, Maiden Surname) GRACE E. DAVENPORT			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) KATHERINE J. MILLER - DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6104 GRANBY ROAD, DERWOOD, MARYLAND 20855			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRFAX CREMATORY		20c. Date 1-4-2000		20d. Location - City or Town, State FAIRFAX, VIRGINIA	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE., SILVER SPRING, MD 20904			
	23a. Particular the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 4 DAYS			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC CARDIOMYOPATHY END STAGE RENAL FAILURE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number D21340		29d. Date signed (Month, Day, Year) DECEMBER 31, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMOND A. BASS, M.D., 3941 FERRARA DRIVE, WHEATON, MARYLAND 20906							
State Registrar	31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature 					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42540

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte Lucile Hill Mayhew

2. Date of Death
Month Day Year
December 31, 19993. Time of Death
14:06

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

274-66-0975

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
April 3, 1914

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Ohio

10b. County

Franklin

10c. City, Town or Location

Columbus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3526 Rue de Fleur

10f. Zip Code

43221

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry S. Hill

18. Mother's Name (First, Middle, Maiden Surname)

Della Merrill

19a. Informant's Name/Relationship (Type, Print)

Mary Ann Mayhew/Daughter-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10812 Admirals Way, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Evergreen Cemetery

Date

Jan. 5,
2000

20c. Location - City or Town, State

Streetsboro, Ohio

21. Signature of Funeral Service Licensee

 M00803
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue
Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Ventricular Fibrillation

Minutes

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Acute Myocardial Infarction

Minutes

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

D47093

29d. Date signed (Month, Day, Year)

December 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Thai McGreivy, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

State
Registrar

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42541

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Viola Lucile Marquardt				2. Date of Death Month Day Year December 30, 1999		3. Time of Death 4:45 PM	
	4a. Facility Name (If not institution, give street and number) 6104 Wayside Drive				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 215-32-3610		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) October 11, 1912	
	9. Birthplace (State or Foreign Country) Missouri		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6104 Wayside Drive		10f. Zip Code 20852		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Eli John Elkins				18. Mother's Name (First, Middle, Maiden Surname) Celia Idona Johnson			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Neil E. Marquardt / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6104 Wayside Dr., Rockville, Maryland 20852			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Park		20c. Location - City or Town, State Norfolk, Nebraska		20d. Date 1/4/2000	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee M00896				22. Name and Address of Facility Robert A. Humphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple infarction dementia Due to (or as a consequence of): b. Cerebrovascular disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 years			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Hubert J. Alpert, M.D.				29c. License number D00143 MD		29d. Date signed (Month, Day, Year) December 30, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hubert J. Alpert, M.D., 8630 Fenton St. #230, Silver Spring, Maryland 20910							
State Registrar	31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature B. Sparks			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42542

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Edward Miller

2. Date of Death
Month Day Year
December 26, 1999

3. Time of Death
1:30 am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

218-52-8355

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 9, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3419 Floral Street

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Year or Dates: 1968-1971

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Equipment Operator

16b. Kind of Business/Industry

Park & Planning

17. Father's Name (First, Middle, Last)

James Henry Miller

18. Mother's Name (First, Middle, Maiden Surname)

Margaret E. Royce

19a. Informant's Name/Relationship (Type, Print)

Maria S. Miller/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3419 Floral Street, Wheaton, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12/29/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd, W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

several hrs

b. Chronic Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Essential Hypertension

Non-Insulin Dependant Diabetes Mellitus

Morbid Obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andrew J. Cole

29c. License number

D14464

29d. Date signed (Month, Day, Year)

12-26-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles L. Franklin, Jr., 11120 New Hampshire Ave., #408, Silver Spring, MD 20904

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42543

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles V. Moyer

2. Date of Death

Month Day Year
December 30, 1999

3. Time of Death

2:33 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

413 Lanark Way

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-34-1799

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb 14, 1930

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

413 Lanark Way

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates: 1951-195313. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

NASA

17. Father's Name (First, Middle, Last)

Charles J. Moyer

18. Mother's Name (First, Middle, Maiden Surname)

Florence Sinclair

19a. Informant's Name/Relationship (Type, Print)

Marion W. Moyer / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 Lanark Way, Silver Spring, MD 20901

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

12/31/99

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Amiotrophic Lateral Sclerosis

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D47928

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lila Bahadori, M.D.

10301 Georgia Ave Silver Spring, MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42544

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen Vetta Mode				2. Date of Death Month Day Year December 29, 1999				3. Time of Death 11:50 am	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 386-12-9819		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Jan 10, 1921		9. Birthplace (State or Foreign Country) Tennessee	
	10a. State Maryland				10b. County Prince George's		10c. City, Town or Location Hyattsville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 6703 Fortieth Avenue				10f. Zip Code 20782		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk				16b. Kind of Business/Industry A&P Grocery Store			
	17. Father's Name (First, Middle, Last) Andy J. Proffitt				18. Mother's Name (First, Middle, Maiden Surname) Susan Pierce					
	19a. Informant's Name/Relationship (Type, Print) Pauline Proffitt / Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14640 Russell Ave., Allen Park, MI 48101					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 1/4/00		20c. Location - City or Town, State Brentwood, MD			
	21. Signature of Funeral Service Licensee <i>J. Keis Skole</i>				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiopulmonary Arrest</i> Due to (or as a consequence of): b. <i>Chronic obstructive Lung Disease</i> Due to (or as a consequence of): c. <i>Congestive Cardiac Failure</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 30 minutes Several years Several years					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>M. Karim MD</i>		29c. License number D18895		29d. Date signed (Month, Day, Year) December 29, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD 20912										
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature <i>B. Sparks</i>								

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42545

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN FRANCIS MILLER				2. Date of Death Month Day Year DECEMBER 28, 1999		3. Time of Death 6:10 PM	
	4a. Facility Name (If not institution, give street and number) 1011 QUAKER KNOLL ROAD				4b. City, Town, or Location of Death SANDY SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 579 48 6048		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) AUG. 3, 1908	
	9. Birthplace (State or Foreign Country) ILLINOIS							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State N.H.		10b. County CARROLL		10c. City, Town or Location CHOCORUA			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 464 WASHINGTON HILL ROAD				10f. Zip Code 03817		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE		16b. Kind of Business/Industry ECONOMIC RESEARCH			
	17. Father's Name (First, Middle, Last) FRANK L. MILLER				18. Mother's Name (First, Middle, Maiden Surname) MINNIE EYERLY			
	19a. Informant's Name/Relationship (Type, Print) RUTH R. MILLER, WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 QUAKER KNOLL ROAD, SANDY SPRING, MD. 20860			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		Date 12/30/99		20c. Location - City or Town, State ALEXANDRIA, VA.	
	21. Signature of Funeral Service Licensee Muriel H. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882			
	Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Approximate interval Between Onset and Death ONE YEAR								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) WINTER RESIDENCE						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Thomas G. Dooley, MD				29c. License number D16450		29d. Date signed (Month, Day, Year) Dec 30, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Dooley, MD 17904 Georgia Avenue Olney, MD 20832								
State Registrar	31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature James B. Sparks			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

99 42546

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23apt1&11,24b,25,26 perMEOG781 3/20/2000 EW

Certificate of Death

Reg. No.

99 42547

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) JOSEPH WALTER O'CONNOR				2. Date of Death Month Day Year DECEMBER 30, 1999		3. Time of Death 11:23AM																														
4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death TAKOMA PARK		4c. County of Death MONTGOMERY																														
5. Social Security Number 028-14-7314		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 11, 1926																														
9. Birthplace (State or Foreign Country) MASSACHUSETTS																																				
Usual Residence of Decedent																																				
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
10e. Street and Number 3428 KILKENNY STREET				10f. Zip Code 20904		10g. Citizen of What Country? USA																														
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 1944 If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE																														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) AERO-SPACE ENGINEER		16b. Kind of Business/Industry FEDERAL GOVERNMENT/ NASA																														
17. Father's Name (First, Middle, Last) JOHN F. O'CONNOR				18. Mother's Name (First, Middle, Maiden Surname) HELEN V. HEHIR																																
19a. Informant's Name/Relationship (Type, Print) ANGELA M. O'CONNOR (SPOUSE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3428 KILKENNY ST. SILVER SPRING, MD 20904																																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD VETERANS AT CROWNSVILLE		Date 1-5-2000		20c. Location - City or Town, State CROWNSVILLE, MARYLAND																														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904																																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																				
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6"> CONGESTIVE HEART FAILURE CONGESTIVE CARDIOMYOPATHY Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE </td> <td>Approximate Interval Between Onset and Death YEARS</td> </tr> <tr> <td colspan="6"> ATRIAL FIBRILLATION Due to (or as a consequence of): </td> <td>4 MONTHS</td> </tr> <tr> <td colspan="6"> CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of): </td> <td>YEARS</td> </tr> <tr> <td colspan="6"> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	CONGESTIVE HEART FAILURE CONGESTIVE CARDIOMYOPATHY Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						Approximate Interval Between Onset and Death YEARS	ATRIAL FIBRILLATION Due to (or as a consequence of):						4 MONTHS	CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of):						YEARS	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						
Immediate Cause (Final disease or condition resulting in death)	CONGESTIVE HEART FAILURE CONGESTIVE CARDIOMYOPATHY Due to (or as a consequence of): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						Approximate Interval Between Onset and Death YEARS																													
	ATRIAL FIBRILLATION Due to (or as a consequence of):						4 MONTHS																													
	CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or as a consequence of):						YEARS																													
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last																																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SMALL LACERATION OF SCALP DUE TO TERMINAL INJURY ATRIAL FIBRILLATION CHRONIC OBSTRUCTIVE PULMONARY DISEASE						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																				
29b. Signature and title of certifier 				29c. License number D 27837		29d. Date signed (Month, Day, Year) JANUARY 3, 2000																														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOUIS J. LARCA 7600 CARROLL AVE, TAKOMA PARK, MD 20912																																				
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature 																																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

515

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42548

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) JEAN EVE PANEK		2. Date of Death Month Day Year DECEMBER 29, 1999		3. Time of Death 2:15 PM	
4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL			4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY
5. Social Security Number 345-01-5171		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	8. Date of Birth (Month, Day, Year) Dec 8, 1918	9. Birthplace (State or Foreign Country) Illinois
Usual Residence of Decedent					
10a. State Colorado		10b. County El Paso		10c. City, Town or Location Colorado Springs	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3475 Hunterwood Drive		10f. Zip Code 80916	
10g. Citizen of What Country? United States		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) John Gwondz	
18. Mother's Name (First, Middle, Maiden Surname) Sophie Maj		19a. Informant's Name/Relationship (Type, Print) Janean Panek, daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11503 Summer Oak Drive, Germantown, MD 20874	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEPSIS Due to (or as a consequence of): Funeraria Acute Renal Failure Due to (or as a consequence of): Acute Respiratory Failure	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
29c. License number 451280		29d. Date signed (Month, Day, Year) December 29, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anushiravan Dadgar, M.D., 13219 Executive Park Terrace, Germantown, MD 20874	
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42549

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Kirk Rowbotham				2. Date of Death Month Day Year Dec. 28, 1999		3. Time of Death 6:00 AM	
	4a. Facility Name (If not institution, give street and number) Haven Home				4b. City, Town, or Location of Death Potomac		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 160-09-8173	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar. 19, 1910		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County Montgomery	10c. City, Town or Location Potomac			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 11834 Goya Drive			10f. Zip Code 20854		10g. Citizen of What Country? U.S.A		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) I		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry At Home			
	17. Father's Name (First, Middle, Last) Frank Kirk				18. Mother's Name (First, Middle, Maiden Sumama) Florence Longo			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sarah B. Smith-Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4220 Fordham Rd. NW, Washington, DC 20016				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		Data 1/3/2000		20c. Location - City or Town, State Arlington, VA	
	21. Signature of Funeral Service Licensee			22. Name and Address of Facility Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>ARRHYTHMIA</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier		29c. License number H51280		29d. Date signed (Month, Day, Year) JAN. 5, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DADGAR 13219 EXECUTIVE PARK TERRACE, GERMANTOWN, MD.								
31. Date filed (Month, Day, Year) JAN 06 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42550

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLORIA ROTTER

2. Date of Death

Month 12 Day 31 Year 99

3. Time of Death

3:40 AM

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL HOSPITAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

130.22.3194

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 04.02.1929

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

15101 INTERLACHEN DRIVE #523

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

RESEARCH ASSISANT

16b. Kind of Business/Industry

PHYSICS

17. Father's Name (First, Middle, Last)

IRVING LIPANSKY

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE FEINSTEIN

19a. Informant's Name/Relationship (Type, Print)

CINDY MENDITCH/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6709 ARROYO COURT, ROCKVILLE, MARYLAND 20852

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MOUNT LEBANON CEMETERY

Date

01.02.00 ADELPHI, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald W. Riverburgh

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

PERFORATION OF DIVERTICULAR ABSCESS

Approximate
Interval Between
Onset and Death

2 WEEKS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BREAST CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Chitra Raju M.D.

29c. License number

MARYLAND D 42452

29d. Date signed (Month, Day, Year)

DECEMBER 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHITRA RAJA GOPAL, M.D.

18111, PRINCE PHILIP DRIVE, #327, OLNEY MARYLAND 20932

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42551

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Esther Repps Rotkin						2. Date of Death Month Day Year December 28, 1999		3. Time of Death 3:30 PM	
	4a. Facility Name (If not institution, give street and number) 15100 Interlachen Dr. #807						4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 054-03-6001		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 28, 1917		9. Birthplace (State or Foreign Country) Poland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 15100 Interlachen Dr. #807				10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher			16b. Kind of Business/Industry Education			
	17. Father's Name (First, Middle, Last) Ernest Repps						18. Mother's Name (First, Middle, Maiden Surname) Rose Blatt			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Irving J. Rotkin/ Husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15100 Interlachen Dr. #807, Silver Spring, MD 20906			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Lebanon Cemetery		Date Dec. 31, 1999		20c. Location - City or Town, State Adelphi, Maryland			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	<div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>CEREBROVASCULAR ACCIDENT</u></p> <p>Due to (or as a consequence of):</p> <p>b. <u>ATRIAL FIBRILLATION</u></p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> </div> </div>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D14440		29d. Date signed (Month, Day, Year) 12/30/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEROMUS SCHWAPP MD 11161 NEW HAMPSHIRE AVENUE Silver Spring										
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 302-358-0000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42552

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Royal Edwin Rostenbach				2. Date of Death Month Day Year Dec. 22 1999		3. Time of Death 8:20 P.M.		
	4a. Facility Name (If not institution, give street and number) Manor Care - Bethesda				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 406-12-7496		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 20, 1912		
	9. Birthplace (State or Foreign Country) Iowa		10a. State MD		10b. County Montgomery		10c. City, Town or Location Bethesda		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6111 Wiscasset Road		10f. Zip Code 20816		10g. Citizen of What Country? U. S. A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 + College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemical Engineer		16b. Kind of Business/Industry Chemical, Environment & Energetic Engineering		17. Father's Name (First, Middle, Last) Robert Rostenbach		18. Mother's Name (First, Middle, Maiden Surname) Ivah Thoene	
19a. Informant's Name/Relationship (Type, Print) Burton Bridgens - Bro.-in-law		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5597 Seminary Road Falls Church, Virginia 22041		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Buffalo Cemetery		20c. Location - City or Town, State 1/8/2000 Buffalo, Iowa	
21. Signature of Funeral Service Licensee Thomas E. Hornbaker		22. Name and Address of Facility Joseph Gawler's Sons 5130 WI Ave. N.W. Washington, D. C. 20016		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Arrhythmia		Approximate Interval Between Onset and Death			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier G. Chablani		29c. License number 42518		29d. Date signed (Month, Day, Year) Dec 23, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani, Md., 11119 Rockville Pike #316, Rockville, Md. 20852	
31. Date filed (Month, Day, Year) JAN 05 2000		32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42553

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ROSE SUSSKIND

2. Date of Death

12 30 99

3. Time of Death

720PM

4a. Facility Name (If not institution, give street and number)

Manorcare Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

083-18-8930

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

97

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 15, 1902

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6530 Democracy Blvd.

10f. Zip Code

20817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Anselm (Anschel) Kris

18. Mother's Name (First, Middle, Maiden Summa)

Bertha Kris

19a. Informant's Name/Relationship (Type, Print)

Emily Susskind/ Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

525 West End Ave., New York, New York 10024

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Moriah Cemetery

Date

Jan 2, 2000

20c. Location - City or Town, State

Fairview, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Memorial Chapels, Inc.

1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSON'S DISEASE

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35791

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M VEMURY 9801 GEORGIA AVE SILVER SPRING MD 20902

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42554

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

PARKER ALAN STENNETT

2. Date of Death

DEC 28 Day 1999 Year

3. Time of Death

12:47 PM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

none

6. Sex

XX M 2 F

7. Age (in yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

DEC 28 1999

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

VA

10b. County

Loudoun

10c. City, Town or Location

Middleburg

10d. Inside City Limits

1 Yes 2 No

XX

10e. Street and Number

Box 1535

10f. Zip Code

20118

10g. Citizen of What Country?

USA

11. Marital Status

XX Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
none

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

none

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Brett Alan Stennett

18. Mother's Name (First, Middle, Maiden Surname)

Kristen Page Draisey

19a. Informant's Name/Relationship (Type, Print)

Kristen P. Stennett - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Box 1535 Middleburg, Virginia 20118

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Middleburg Memorial Cem. 12/31/99 Middleburg, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, Virginia 22310

23a. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. EXTREME PREMATUREITY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending Investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

DEC 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JEROME V. PONDER, CAPT, MC, USA

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

State
Registrar

31. Date filed (Month, Day, Year)

JAN 06 2000

32. Registrar's Signature

Jenna B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F

Certificate of Death

Reg. No.

99 42555

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Richard Steiner		2. Date of Death Month December Day 31 Year 1999		3. Time of Death 8:20 A.M.
	4a. Facility Name (If not institution, give street and number) 8301 Wisconsin Avenue		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery
Funeral Director	5. Social Security Number 456-21-3992	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 44 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Nov. 3, 1955		9. Birthplace (State or Foreign Country) Mexico		
Usual Residence of Decedent					
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number 5315 Wehawken Road		10f. Zip Code 20816		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: Mexican	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chef		16b. Kind of Business/Industry O'Donnells	
17. Father's Name (First, Middle, Last) Henry Malcolm Steiner		18. Mother's Name (First, Middle, Maiden Surname) Altagracia Landeros			
19a. Informant's Name/Relationship (Type, Print) Henry M. Steiner/Father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5315 Wehawken Road Bethesda, MD 20816			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Jan 4, 2000 Alex., Virginia	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, D.C. 20007			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. NARCOTIC INTOXICATION			
Due to (or as a consequence of):		b. 			
Due to (or as a consequence of):		c. 			
Due to (or as a consequence of):		d. 			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 12-31-99		28b. Time of Injury FOUND: 9:15	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		28e. Location (Street and Number or Rural Route Number, City or Town, State) 8301 WISCONSIN AVE. SILVER SPRING, MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 01, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R Fowler 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 05 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42556

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Udom Srivarin

2. Date of Death
Month Day Year
December 30, 19993. Time of Death
0224

4a. Facility Name (If not Institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

none

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 25, 1929

9. Birthplace (State or Foreign Country)

Thailand

Usual Residence of Decedent

10a. State

Thailand

10b. County

N/A

10c. City, Town or Location

Bangkok

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4/36 Tawanna Village, Phahonyathin Rd. 23

10f. Zip Code

10900

10g. Citizen of What Country?

Thailand

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Asian

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Chief Editor

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Yongkim Srivalin

18. Mother's Name (First, Middle, Maiden Surname)

Thongsuk Xiao

19a. Informant's Name/Relationship (Type, Print)

John Hsu/Son-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2529 Lindley Terrace, Rockville, Maryland 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

Dec. 31,

1999

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M01126

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc., 300 West Montgomery Avenue,
Rockville, Maryland 20850-2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Rupture of Myocardium

Minutes

Due to (or as a consequence of):

b. Acute Myocardial Infarction

Minutes

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah Sherrill, M.D., 9901 Medical Center Dr., Rockville, MD 20850

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 12557

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DAVID E. SOLOMONSON				2. Date of Death Month DECEMBER Day 30 Year 1999		3. Time of Death 2340	
	4a. Facility Name (If not institution, give street and number) HUT CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 219-42-4375		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) 4-15-1943	
	9. Birthplace (State or Foreign Country) OHIO		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 10319 INSLEY ST.		10f. Zip Code 20902		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GRAPHIC DESIGNER		16b. Kind of Business/Industry ADVERTISING				
17. Father's Name (First, Middle, Last) SAMUEL SOLOMONSON				18. Mother's Name (First, Middle, Maiden Surname) FRIEDA BELLE GOODMAN				
19a. Informant's Name/Relationship (Type, Print) SAMUEL SOLOMONSON FATHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10319 INSLEY ST. Silver Spring, MD 20902				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GDNS		Date 1-3-00		20c. Location - City or Town, State FALLS CHURCH, VA		
21. Signature of Funeral Service Licensee Ronald W. Riverbaugh				22. Name and Address of Facility DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ANTERIOSCROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier CARL MARGOLIS (ME)				29c. License number 015236		29d. Date signed (Month, Day, Year) DECEMBER 31, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL MARGOLIS, MD, 1175 ROCKVILLE PIKE, ROCKVILLE MD 20852								
31. Date filed (Month, Day, Year) JAN 06 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42558

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SADIE SOLOMON				2. Date of Death Month Day Year 12.30.1999				3. Time of Death 7:42 AM				
	4a. Facility Name (If not Institution, give street and number) 14508 HOMECREST ROAD #511				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY				
Funeral Director	5. Social Security Number 253.56.8221		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.				
	6. Date of Birth (Month, Day, Year) 03.30.1909		9. Birthplace (State or Foreign Country) RUSSIA		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 14508 HOMECREST ROAD #511		10f. Zip Code 20906		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PARTNER			
16b. Kind of Business/Industry RESTAURANT		17. Father's Name (First, Middle, Last) MAX GASPIN		18. Mother's Name (First, Middle, Maiden Surname) LIZZA SILVERMAN		19a. Informant's Name/Relationship (Type, Print) BARBARA ROTHENBERG/DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 JAYSTONE PL, SILVER SPRING, MARYLAND 20905					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GARDENS		20c. Location - City or Town, State 12.31.99 OLNEY, MARYLAND		21. Signature of Funeral Service Licensee Donald C. Stettin		22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEVERE CORONARY ARTERY DISEASE Due to (or as a consequence of): VENTRICULAR TRACHYCARDIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SEVERE PERIPHERAL VASCULAR DISEASE Due to (or as a consequence of):		Approximate Interval Between Onset and Death 1 YEAR 1 YEAR		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier DR. MICHAEL BARTH		29c. License number D32009		29d. Date signed (Month, Day, Year) 01.04.2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MICHAEL BARTH, MD 11161 NEW HAMPSHIRE AVE, SILVER SPRING, MARYLAND 20904					
31. Date filed (Month, Day, Year) JAN 05 2000		32. Registrar's Signature Anna B. Sparks											

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42559

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARY SMITH

2. Date of Death

Month Day Year
DECEMBER 29, 1999

3. Time of Death

1:27pm

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

578-34-3410

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
May 19, 1913

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2217 Richland Street

10f. Zip Code

20910

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

James Crockett

18. Mother's Name (First, Middle, Maiden Surname)

Mary Brandon

19a. Informant's Name/Relationship (Type, Print)

Jean Seagars-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2217 Richland St., Silver Spring, MD 20910

20a. Method of Disposition

X ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rock Creek Cemetery

Date

1/4/2000

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

► 

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.
600 Kennedy Street, N.W., Wash., DC 2001123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Chronic Obstructive Lung Disease

Due to (or as a consequence of):

d. Bilateral Plural Effusions

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

X ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

►  MD

29c. License number

D35791

29d. Date signed (Month, Day, Year)

December 30, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Merlyn Vemury 9801 Georgia Avenue, Silver Spring, MD 20906

State
Registrar

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

► 

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42560

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) INGA GRUNEWALD SHARP						2. Date of Death Month Day Year DECEMBER 31, 1999		3. Time of Death 2:30 P.M.	
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL						4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 102-03-5539		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 4, 1902		9. Birthplace (State or Foreign Country) GERMANY	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 8505 SPRINGVALE ROAD				10f. Zip Code 20910		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MILLINER			16b. Kind of Business/Industry HAT MAKER		
	17. Father's Name (First, Middle, Last) UNKNOWN						18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) LISA A MARTIN - GRANDDAUGHTER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16616 HARBOUR TOWN DRIVE, SILVER SPRING, MD 20905			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CYPRESS HILLS CEMETERY		20c. Location - City or Town, State 1/10/00 BROOKLYN, NY			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE SILVER SPRING, MD 20904			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RESPIRATORY FAILURE Due to (or as a consequence of): b. ASPIRATION Due to (or as a consequence of): c. MALNUTRITION Due to (or as a consequence of): d. DEHYDRATION									
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 15 MIN. 15 MIN. 2 MONTHS									
State Registrar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number D40804			29d. Date signed (Month, Day, Year) DECEMBER 31, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEWAL K. SHARMA, MD 10620 GEORGIA AVENUE SILVER SPRING, MD 20902										
31. Date filed (Month, Day, Year) JAN 05 2000										
32. Registrar's Signature 										

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42561

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NEANG SUM				2. Date of Death Month Day Year OCTOBER 28 1999				3. Time of Death 1641	
	4a. Facility Name (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				4b. City, Town, or Location of Death THIRTON PARK				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 216-41-3300		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) FEB. 3, 1930		9. Birthplace (State or Foreign Country) CAMBODIA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1000 QUEBEC TERRACE #103				10f. Zip Code 20903		10g. Citizen of What Country? CAMBODIA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: ASIAN		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FACTORY WORKER				16b. Kind of Business/Industry MANUFACTURING	
	17. Father's Name (First, Middle, Last) NEANG SUM				18. Mother's Name (First, Middle, Maiden Surname) SOME MEK					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) YAN DOEUK/SPOUSE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 QUEBEC TERRACE #103 SILVER SPRING, MARYLAND 20903					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATORY		Date 1/1/2000		20c. Location - City or Town, State BELTSVILLE, MARYLAND			
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ISCHEMIC MYOCARDIAL DISEASE										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier [Signature] (M.D.)				29c. License number 015236		29d. Date signed (Month, Day, Year) December 28, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL MAGGALL, M.D. 1125 ROCKVILLE PIKE, ROCKVILLE, MONTGOMERY										
State Registrar	31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature [Signature] B. Sparks					

ORIGINAL

CONO SCOLARO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42562

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CONO SCOLARO				2. Date of Death Month Day Year DECEMBER 31, 1999				3. Time of Death 5:07AM	
	4a. Facility Name (If not institution, give street and number) 6647 ISLE OF SKYE DRIVE				4b. City, Town, or Location of Death HIGHLAND				4c. County of Death HOWARD	
Funeral Director	5. Social Security Number 217-42-4914		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) JULY 11, 1930		9. Birthplace (State or Foreign Country) ITALY	
	Usual Residence of Decedent									
10a. State MD		10b. County HOWARD		10c. City, Town or Location HIGHLAND				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 6647 ISLE OF SKYE DRIVE				10f. Zip Code 20777				10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BARBER				16b. Kind of Business/Industry RETAIL/HAIR		
17. Father's Name (First, Middle, Last) JOSEPH SCOLARO				18. Mother's Name (First, Middle, Maiden Surname) CATENA SPATICCHIA						
19a. Informant's Name/Relationship (Type, Print) SEBASTIANA SCOLARO (SPOUSE)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6647 ISLE OF SKYE DRIVE HIGHLAND, MD 20777						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GATE OF HEAVEN CEMETERY		Date 1-4-2000		20c. Location - City or Town, State SILVER SPRING, MD				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904						
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>RENAL CELL CANCER</u></p> <p>Due to (or as a consequence of):</p> <p>b. <u>RESPIRATORY ARREST</u></p> <p>Due to (or as a consequence of):</p> <p>c. _____</p> <p>Due to (or as a consequence of):</p> <p>d. _____</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><u>~4 YEARS</u></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number D45014				29d. Date signed (Month, Day, Year) January 1/2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ISABELLA MARTIRE, M.D. 3418 OLANWOODS COURT #111 OLNEY MD 20832										
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42563

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Enzo Santucci				2. Date of Death Month Day Year December 31, 1999				3. Time of Death 8:10 pm	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-54-4756		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Sep 25, 1940	
	9. Birthplace (State or Foreign Country) Italy		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Usual Residence of Decedent		10e. Street and Number 2703 Woodedge Road				10f. Zip Code 20906		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Barber				16b. Kind of Business/Industry Hair				
17. Father's Name (First, Middle, Last) Ferruccio Santucci				18. Mother's Name (First, Middle, Maiden Summa) Rachele Collepardo						
19a. Informant's Name/Relationship (Type, Print) Olga Santucci/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2703 Woodedge Road, Silver Spring, MD 20906						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery				20c. Location - City or Town, State 1/5/2000 Silver Spring, MD				
21. Signature of Funeral Service Licensee Robert E. Ramsey				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypotension Due to (or as a consequence of): b. Respiratory Failure Due to (or as a consequence of): c. Renal Failure Due to (or as a consequence of): d. Stroke Approximate Interval Between Onset and Death 3 days 3 days										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Shomeesh MD				29c. License number D40804				29d. Date signed (Month, Day, Year) January 1, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kewal K. Sharma, M.D. 10620 Georgia Ave., #114, SilverSpring, MD 20902										
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12561

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RENA SAIDMAN				2. Date of Death Month 12 Day 30 Year 1999		3. Time of Death 3:40 AM		
	4a. Facility Name (If not institution, give street and number) CASEY HOUSE				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 577-10-0972		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/3/1912	9. Birthplace (State or Foreign Country) OHIO	
	Usual Residence of Decedent								
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 15101 GLADE DRIVE APT. #3A				10f. Zip Code 20906		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BOOKKEEPER			16b. Kind of Business/Industry RETAIL		
17. Father's Name (First, Middle, Last) JULIUS SAND				18. Mother's Name (First, Middle, Maiden Surname) SARAH FUNGER					
19a. Informant's Name/Relationship (Type, Print) SANFORD E. SAIDMAN (SON)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 KEYSTONE COURT, GAITHERSBURG, MARYLAND 20878					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) KING DAVID MEMORIAL GARDENS		Date 12/31/99		20c. Location - City or Town, State FALLS CHURCH, VA			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. METASTATIC OVARIAN CARCINOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 13 MONTHS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number D0037620		29d. Date signed (Month, Day, Year) DECEMBER 30, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK S. GODEC, M.D., CASEY HOUSE, 6001 MUNCASTER MILL ROAD, ROCKVILLE, MD 20855									
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42565

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Frank Smetana Jr.

2. Date of Death
Month Day Year
December 29, 19993. Time of Death
5:31PM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

219-30-3388

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 20, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Queen Anne's

10c. City, Town or Location

Stevensville

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

910 Worcester Drive

10f. Zip Code

21666

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Tool and Die Maker

16b. Kind of Business/Industry

Telecommunications

17. Father's Name (First, Middle, Last)

James F. Smetana, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Regan

19a. Informant's Name/Relationship (Type, Print)

Carolyn Margaret Smetana/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

910 Worcester Rd. Stevensville, MD 21666

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Cremation Center December 30, 1999 Chester, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Chal M. Helfenbein

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home
106 Shamrock Rd. Chester, Maryland 2161923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. W. M. M. M.

29c. License number

D38445

29d. Date signed (Month, Day, Year)

Dec 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eric W. Wainman 600 Ridgeley Ave, Annapolis MD 21401

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

*B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42566

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pearline H. Taylor				2. Date of Death Month Day Year December 22 1999				3. Time of Death 6:00 P.M.	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 214-60-6729		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 29, 1929		9. Birthplace (State or Foreign Country) Jamaica	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Hyattsville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1001 Chillum Road #204				10f. Zip Code 20782		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own home		
	17. Father's Name (First, Middle, Last) Unavailable				18. Mother's Name (First, Middle, Maiden Summa) Claradine Edwards Higglar					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Carlton Henry / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Chillum Road #204 Hyattsville, Md. 20782					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Data Dec. 31 1999		20c. Location - City or Town, State Silver Spring, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW Washington, DC 20007					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of the Ovary with Metastasis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D20129		29d. Date signed (Month, Day, Year) January 4, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Chacko, M.D. 7610 Carroll Avenue #390. Takoma Park, Maryland 20912									
31. Date filed (Month, Day, Year) JAN 05 2000		32. Registrar's Signature 								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42567

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE M. VINSON

2. Date of Death

Month Day Year
DEC. 28, 1999

3. Time of Death

0345

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

218-32-6005

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
July 20, 1922

9. Birthplace (State or Foreign Country)

S. Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17060 King James Way, #605

10f. Zip Code

20877

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
5th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

James Wiggins, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances Beale

19a. Informant's Name/Relationship (Type, Print)

Jerome Vinson (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2302 Gaylord Dr., Suitland, MD 20746

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan F/Srv. 1/2/2000 Alexandria, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Pulmonary Embolism

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Acute Abdominal Pain

Due to (or as a consequence of):

c. Ovarian, Endometrial Tumor.

Due to (or as a consequence of):

d. Urinary tract infection, Diabetes mellitus.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, absent

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Helen D. Khirany, MD.

29c. License number

D22978

29d. Date signed (Month, Day, Year)

DECEMBER 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen D. Khirany 19520 Doctors Drive, Germantown, MD 20874.

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42568

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA L. YOWAISKI

2. Date of Death

December 31, 1999

3. Time of Death

3:45 pm

4a. Facility Name (If not institution, give street and number)

13201 Hathaway Drive

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

577-28-9302

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 10, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13201 Hathaway Drive

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Assistant Chief Operator

16b. Kind of Business/Industry

C&P Telephone

17. Father's Name (First, Middle, Last)

William Parran Farr

18. Mother's Name (First, Middle, Maiden Surname)

Martha Davis

19a. Informant's Name/Relationship (Type, Print)

James M. Yowaiski / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13201 Hathaway Drive, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

1/5/2000

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D22028

29d. Date signed (Month, Day, Year)

1-3-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul S. Rhodes M.D., 1667 Crofton Center, Crofton, MD 21114

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

First of all
I am very sorry

50-2-1 85-11-11 1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 2 per DR G7813/28/00dhhb State of Maryland / Department of Health and Mental Hygiene
Amend Item 4a, 23b per PHY, 10b, 10f, 19b per ABG781 3/28/2000

Certificate of Death

Reg. No.

99 42569

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Dietrich				2. Date of Death Month December Day 30 , Year 1999		3. Time of Death PM 12:00 AM	
	4a. Facility Name (If not institution, give street and number) 973 Fall Circle Way				4b. City, Town, or Location of Death Gambrills		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 512-48-1140		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 6, 1950	9. Birthplace (State or Foreign Country) Kansas
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Gambrills			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 973 Fall Circle Way				10f. Zip Code 21050 21054		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry own home		
17. Father's Name (First, Middle, Last) Harry Heckmann				18. Mother's Name (First, Middle, Maiden Surname) Margaret Crawford				
19a. Informant's Name/Relationship (Type, Print) James Dietrich/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 973 Fall Circle Way Gambrills, MD 21050				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Data		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Lung Cancer								Approximate Interval Between Onset and Death 2 yrs.
23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):								
23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):								
23d. Part IV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number 031551		29d. Date signed (Month, Day, Year) January 10, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dorella DeLucia 16005-Crown High way, Ste 602, Wt. Bm. - 21061								
31. Date filed (Month, Day, Year) JAN 19 2000				32. Registrar's Signature Sparks				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

JERRY AMEND ITEMS: #23 PART 1, 27, 28A-E PER MEO G779 1-21-2000 WR. 99 42570
LONG
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JERRY LEE LONG		2. Date of Death Month Day Year DECEMBER 30, 1999		3. Time of Death 1:27P.M.
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A
Funeral Director	5. Social Security Number 212-60-4886	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 46 Yrs.	8. Date of Birth (Month, Day, Year) JUNE 7, 1953	9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD.	10b. County N/A	10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10a. Street and Number 231 E. 201/2 ST.		10f. Zip Code 21218		10g. Citizen of What Country? U.S.A.
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: BLACK		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (14 or 5+) N/A		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNEMPLOYED		16b. Kind of Business/Industry N/A		
	17. Father's Name (First, Middle, Last) JOHN LONG		18. Mother's Name (First, Middle, Maiden Surname) ESTHER SPRUILL		
	19a. Informant's Name/Relationship (Type, Print) ISAAC BROWN/FRIEND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2122 E. FAYETTE ST. BALTIMORE, MD. 21231		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZINN CEMETERY		20c. Location - City or Town, State 1/18 LANDSDOWNE, MD
	21. Signature of Funeral Service Licensee <i>Funeral Service Licensee</i>		22. Name and Address of Facility BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO., MD 21213		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COCAINE, ALCOHOL AND NARCOTIC INTOXICATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) 12-30-99 28b. Time of Injury UNKNOWN 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred UNKNOWN 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND NEAR A ROADWAY 28f. Location (Street and Number or Rural Route Number, City or Town, State) 00 MCALEER CT. BALTIMORE, MD					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JANUARY 2, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Funder 111 Penn Street, Baltimore, Maryland 21201					
State Registrar	31. Date filed (Month, Day, Year) JAN 19 2000		32. Registrar's Signature <i>[Signature]</i>		

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42571

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) June Schultz		2. Date of Death Month Day Year DECEMBER 13, 1999		3. Time of Death 1040 AM	
4a. Facility Name (If not institution, give street and number) 1027 CATHEDRAL STREET APARTMENT 11K		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
5. Social Security Number unknown	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	8. Date of Birth (Month, Day, Year) June 4, 1928	9. Birthplace (State or Foreign Country) unknown	
Usual Residence of Decedent		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10a. State MD		10b. County N/A		10f. Zip Code 21201	
10e. Street and Number 1027 Cathedral Street		10g. Citizen of What Country? USA			
11. Marital Status unknown 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown	
17. Father's Name (First, Middle, Last) unknown		18. Mother's Name (First, Middle, Maiden Surname) unknown			
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute Coronary Artery Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <i>inspection</i> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <i>Theresa M. King</i>		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) DECEMBER 14, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>THEODORE M. KING</i> 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 19 2000		32. Registrar's Signature <i>Beverly Sparks</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42572

AMENDED ITEM #25 PER MD G779 1/19/2000 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lula Simpkins

2. Date of Death

December 26, 1999

3. Time of Death

15:51

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

244-28-5721

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 15, 1925

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3304 Pinkney Rd.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Presser

16b. Kind of Business/Industry

Factory

17. Father's Name (First, Middle, Last)

John Dixon

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Davis

19a. Informant's Name/Relationship (Type, Print)

Ms. Jacqueline Howard

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3304 Pinkney Rd. Balto, Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Zion

Date

11/6/2000

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home
2222 W. North Ave. Balto, Md. 2121623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 weeks

b. Multiple Cerebrovascular Accident

Due to (or as a consequence of):

10 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Chronic Aspiration

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Olusegun O. Lawoyin, M.D.

29c. License number

D23724

29d. Date signed (Month, Day, Year)

12-29-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLUSEGUN O. LAWYOIN, M.D. 3901 Greenspring Ave. Ste 301, Baltimore, MD 21211

State
Registrar

31. Date filed (Month, Day, Year)

JAN 19 2000

32. Registrar's Signature

Beverly B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Lula Simpkins
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42573

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) WILLIAM LOUIS ARNICAR				2. Date of Death Month DECEMBER Day 30 Year 1999		3. Time of Death 9:15 AM	
4a. Facility Name (If not institution, give street and number) 20716 TOWNSEND ROAD				4b. City, Town, or Location of Death GAPLAND		4c. County of Death WASHINGTON	
5. Social Security Number 461-74-2048		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 53 Yrs.		8. Date of Birth (Month, Day, Year) MAY 31, 1946	
9. Birthplace (State or Foreign Country) AUSTRALIA		10a. State MARYLAND		10b. County WASHINGTON		10c. City, Town or Location GAPLAND	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 20716 TOWNSEND ROAD		10f. Zip Code 21779		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) RADIOLOGICAL TECHNOLOGIST		16b. Kind of Business/Industry HOSPITAL		17. Father's Name (First, Middle, Last) WILLIAM LEWIS ARNICAR	
18. Mother's Name (First, Middle, Maiden Surname) MAUREEN W. FITZPATRICK		19a. Informant's Name/Relationship (Type, Print) DIANE T. ARNICAR/SPOUSE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20716 TOWNSEND ROAD, GAPLAND, MARYLAND 21779		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) SMITHSBURG CREMATORY		20c. Date 12/30/99		20d. Location - City or Town, State SMITHSBURG, MARYLAND		21. Signature of Funeral Service Licensee  Paul M. Dean	
22. Name and Address of Facility BAST FUNERAL HOME		22b. Address 7606 Old National Pike		22c. City or Town, State, Zip Code Boonsboro, Maryland 21713		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Esophageal Cancer	
23b. Due to (or as a consequence of):		23c. Due to (or as a consequence of):		23d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 2 years	
23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):		23g. Due to (or as a consequence of):		23h. Due to (or as a consequence of):	
23i. Due to (or as a consequence of):		23j. Due to (or as a consequence of):		23k. Due to (or as a consequence of):		23l. Due to (or as a consequence of):	
23m. Due to (or as a consequence of):		23n. Due to (or as a consequence of):		23o. Due to (or as a consequence of):		23p. Due to (or as a consequence of):	
23q. Due to (or as a consequence of):		23r. Due to (or as a consequence of):		23s. Due to (or as a consequence of):		23t. Due to (or as a consequence of):	
23u. Due to (or as a consequence of):		23v. Due to (or as a consequence of):		23w. Due to (or as a consequence of):		23x. Due to (or as a consequence of):	
23y. Due to (or as a consequence of):		23z. Due to (or as a consequence of):		23aa. Due to (or as a consequence of):		23ab. Due to (or as a consequence of):	
23ac. Due to (or as a consequence of):		23ad. Due to (or as a consequence of):		23ae. Due to (or as a consequence of):		23af. Due to (or as a consequence of):	
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23ao. Due to (or as a consequence of):		23ap. Due to (or as a consequence of):		23aq. Due to (or as a consequence of):		23ar. Due to (or as a consequence of):	
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23bu. Due to (or as a consequence of):		23bv. Due to (or as a consequence of):		23bw. Due to (or as a consequence of):		23bx. Due to (or as	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #5 PER F.H. G779 1-31-2000 WR. **Certificate of Death** 99 42574

Reg. No.

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Helen Virginia Adkins		2. Date of Death Month December Day 25 Year 1999		3. Time of Death 12/0 hrs	
4a. Facility Name (If not institution, give street and number) Chestertown Nursing & Rehab. Center		4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
5. Social Security Number 213-74-7588		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.	
8. Date of Birth (Month, Day, Year) February 14, 1905		9. Birthplace (State or Foreign Country) Rock Hall, Maryland			
10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 415 Morgnac Road		10f. Zip Code 21620	
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)	
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home		17. Father's Name (First, Middle, Last) William Williams	
18. Mother's Name (First, Middle, Maiden Surname) Unknown		19a. Informant's Name/Relationship (Type, Print) Margaret Adkins/Daughter-in-Law		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 S. Joplin Street, Baltimore, Maryland 21224	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Chapel Cemetery		20c. Location - City or Town, State 12/28/99 Rock Hall, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Due to (or as a consequence of): b. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d.					
23b. Approximate Interval Between Onset and Death 3 wks					
23c. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23d. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D41587		29d. Date signed (Month, Day, Year) 12/27/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble 122 Speer Road, Suite 5, Chestertown, Maryland 21620					
31. Date filed (Month, Day, Year) DEC 28 1999		32. Registrar's Signature 			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42575

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Malcolm Anderson

2. Date of Death

December 24, 1999

3. Time of Death

4:44 pm

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

215-18-1083

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan 2, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Adamstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2779 Adams Street

10f. Zip Code

21710

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Lab Tech

16b. Kind of Business/Industry

US Gov't

17. Father's Name (First, Middle, Last)

Charles C. Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Nina Merriman

19a. Informant's Name/Relationship (Type, Print)

Betty Anderson / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2779 Adams Street, Adamstown, Md 21710

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Olivet Mausoleum

Date

12/28/99

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike, Frederick, MD 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death2-3
weeksSequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Asthma

Due to (or as a consequence of):

several
years

c. Congestive heart failure

Due to (or as a consequence of):

several days

d. Renal failure acute and chronic

several
months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

vasculitis, cirrhosis, anemia,

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0054705

29d. Date signed (Month, Day, Year)

12/25/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Katharine Buki
300 West 9th Street Frederick MD 21701State
Registrar

31. Date filed (Month, Day, Year)

DEC 27 1999

32. Registrar's Signature

B. Spaw

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42576

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert John Binau

2. Date of Death

December 22, 1999

3. Time of Death

3:08 pm

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

214 484209

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

12-21-46

10. Inside City Limits

1 ☐ Yes 2 ☒ No

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Smithsburg

10e. Street and Number

12010 Hippan Hill Road

10f. Zip Code

21783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Hagerstown City Police

17. Father's Name (First, Middle, Last)

Robinson Binau

18. Mother's Name (First, Middle, Maiden Surname)

Florence Mobley

19a. Informant's Name/Relationship (Type, Print)

Susan Shapiro / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12010 Hippan Hill Rd, Smithsburg, MD 21783

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven

Date

12-23-99 Frederick, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. N. Zumbun

22. Name and Address of Facility

J. N. Zumbun Funeral Home
6028 Sykesville Rd, Sykesville MD 21784

23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxia

Due to (or as a consequence of):

b. elective 9/16 g mechanical ventilation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Bronchitis injury 2° to

Due to (or as a consequence of):

d. Prolonged cerebral anoxia

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. N. Zumbun

29c. License number

D0053071

29d. Date signed (Month, Day, Year)

10/03/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1110 Medical Campus Dr Ste 226, Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

DEC 27 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42577

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Henry Baker					2. Date of Death Month Day Year December 17, 1999			3. Time of Death 0900																																						
	4a. Facility Name (If not Institution, give street and number) 9716 Masser Road					4b. City, Town, or Location of Death Frederick			4c. County of Death Frederick																																						
Funeral Director	5. Social Security Number 220-01-0399		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) April 1, 1914		9. Birthplace (State or Foreign Country) Maryland																																						
	Usual Residence of Decedent																																														
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																						
	10e. Street and Number 9716 Masser Road				10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.																																								
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																																							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) General Contractor			16b. Kind of Business/Industry Construction																																								
	17. Father's Name (First, Middle, Last) George Francis Baker					18. Mother's Name (First, Middle, Maiden Surname) Grace Virginia Harriet Hoffman																																									
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Shirley A. Johnson, Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9716 Masser Road, Frederick, Maryland 21702																																										
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Dec. 20, 1999			20c. Location - City or Town, State Frederick, Maryland																																								
	21. Signature of Funeral Service Licensed Richard E. Yeron MO0255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701																																										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.																																														
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="8">Chronic Obstructive Pulmonary Disease</td> <td>1997</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of): Pulmonary Embolus</td> <td>1997</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td colspan="8">Due to (or as a consequence of): Abdominal Aortic Aneurysm</td> <td>1998</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of): Dysproteinemia</td> <td>1998</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	Chronic Obstructive Pulmonary Disease								1997	Due to (or as a consequence of): Pulmonary Embolus								1997	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): Abdominal Aortic Aneurysm								1998	Due to (or as a consequence of): Dysproteinemia							
Immediate Cause (Final disease or condition resulting in death)	Chronic Obstructive Pulmonary Disease								1997																																						
	Due to (or as a consequence of): Pulmonary Embolus								1997																																						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): Abdominal Aortic Aneurysm								1998																																					
		Due to (or as a consequence of): Dysproteinemia								1998																																					
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Insufficiency							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																							
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																							
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																																					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)																																								
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																														
	29b. Signature and title of certifier Richard G. Yeron, MD					29c. License number D 41717		29d. Date signed (Month, Day, Year) December 20, 1999																																							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard G. Yeron, M.D., 186 Thomas Johnson Drive, Suite 203, Frederick, Md. 21702																																														
	31. Date filed (Month, Day, Year) DEC 23 1999		32. Registrar's Signature B. Spaul																																												

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State of Maryland / Department of Health and Mental Hygiene

99 42578

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JULIA VIRGINIA BABCOCK				2. Date of Death Month Day Year DEC. 26, 1999		3. Time of Death 0950	
	4a. Facility Name (If not institution, give street and number) MAGNOLIA CENTRE				4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 579-09-1724		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 95		8. Date of Birth (Month, Day, Year) AUG. 31, 1904	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD.		10b. County Prince Georges		10c. City, Town or Location Lanham	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 8200 Good Luck Road		10f. Zip Code 20706		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk/Secretary		16b. Kind of Business/Industry Federal Government			
	17. Father's Name (First, Middle, Last) Christian Schade		18. Mother's Name (First, Middle, Maiden Surname) Clementine Virginia Runkles		19a. Informant's Name/Relationship (Type, Print) Evelyn Schade (Niece)			
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5514 Old National Pike, Frederick, Md. 21702		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. Frederick, md 21701					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASYSTOLE Due to (or as a consequence of): b. MYOCARDIAL INFARCTION Due to (or as a consequence of): c. CORONARY ARTERY DISEASE Due to (or as a consequence of): d. ATHEROSCLEROTIC HEART DISEASE		Approximate Interval Between Onset and Death 15 min. 1 hour years years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSIVE HEART DISEASE Status Post Cardiac Pacemaker Placement Cerebrovascular Accident; Hypothyroidism		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D22549		29d. Date signed (Month, Day, Year) December 26, 1999	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. M. Din, MD 6510 Kenilworth Ave. Riverdale, MD. 20737		31. Date filed (Month, Day, Year) DEC 30 1999					
	32. Registrar's Signature 							

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42579

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Webster Black				2. Date of Death December 27, 1999		3. Time of Death 12:50 AM		
	4a. Facility Name (If not institution, give street and number) Glade Valley Nursing Center				4b. City, Town, or Location of Death Walkersville		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 215-26-8399		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 22, 1921		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 9016 Bethel Road		10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1945-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance		16b. Kind of Business/Industry US Government					
17. Father's Name (First, Middle, Last) Charles Vernon Black				18. Mother's Name (First, Middle, Maiden Surname) Marian Augusta Bart					
19a. Informant's Name/Relationship (Type, Print) Mr. Dennis L. Hoffman, Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12445 Catocin Furnace Rd., Thurmont, Md. 21788					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens, Dec. 30, 1999		20c. Location - City or Town, State Frederick, Md.					
21. Signature of Funeral Service Licensee Richard E. Graf M00255		22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. <i>metabolic carcinoma to brain: Pung tumor</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 6 mos					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier [Signature]		29c. License number D-13971		29d. Date signed (Month, Day, Year) December 27, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 W. 9th St FREDERICK, MD 21701		31. Date filed (Month, Day, Year) DEC 29 1999		32. Registrar's Signature [Signature]					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42580

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GAVIN ZANE BURDETTE				2. Date of Death Month 12 Day 28 Year 99		3. Time of Death 5:35pm	
	4a. Facility Name (If not institution, give street and number) UNIVERSITY OF MARYLAND MEDICAL SYSTEMS				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death MARYLAND	
Funeral Director	5. Social Security Number 216-55-6754		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 5 Months 21 Days 21		8. Date of Birth (Month, Day, Year) July 7, 1999	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 560 Hollyberry Way		10f. Zip Code 21703		10g. Citizen of What Country? United States	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Infant		16b. Kind of Business/Industry		16c. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) John Richard Burdette, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Hope Elaine Bentz		19a. Informant's Name/Relationship (Type, Print) John Richard Burdette, Jr., father		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 560 Hollyberry Way Frederick, Maryland 21703	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Date 12/31/99		20d. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702		23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmonary Hypertension Due to (or as a consequence of): SEVERE BRONCHOPULMONARY DYSPLASIA Due to (or as a consequence of): COX PULMONALE		Approximate Interval Between Onset and Death 2 mos 3 mos 2 mos	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 12/28/99	
	28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D-0043985		29d. Date signed (Month, Day, Year) 12/28/99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN J. DULKERIAN, MD, University of Maryland Medical Systems, 225 Greene St BALTIMORE, MD, 21201		31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature <i>[Signature]</i>		33. Registrar's Title B. Sparks	

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42581

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) MARIE LESLIE BERRY		2. Date of Death Month Day Year DEC. 31, 1999		3. Time of Death 0350	
4a. Facility Name (If not institution, give street and number) Frederick Health Care Center			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
5. Social Security Number 219-52-1089	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Mar 15, 1906
9. Birthplace (State or Foreign Country) Virginia					
Usual Residence of Decedent					
10a. State MD.	10b. County Frederick	10c. City, Town or Location Frederick		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 30 North Place		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farming		16b. Kind of Business/Industry Farming			
17. Father's Name (First, Middle, Last) Jack Butler			18. Mother's Name (First, Middle, Maiden Surname) Dorsey Burten		
19a. Informant's Name/Relationship (Type, Print) Gilbert A. Berry, Sr. Husband			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2808 Raleigh Road Walkersville, Md. 21793		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		20c. Location - City or Town, State 12/31/99 Smithsburg, Md.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Robert E. Bailey & Son Funeral Homes, P.A. 1201 N. Market St. Frederick, Md. 21701			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Due to (or as a consequence of): Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerosis Due to (or as a consequence of):					Approximate Interval Between Onset and Death Days years years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Prior Stroke					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number D47556		29d. Date signed (Month, Day, Year) 12/31/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. Johnson, MD 172 T.J. Drive Frederick, Md. 21701					
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42582

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Suzanne Lee Bunitsky				2. Date of Death Month Day Year December 31, 1999		3. Time of Death 5:30 am	
	4a. Facility Name (If not Institution, give street and number) 5400 Holiday Drive				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 219-54-8029		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Dec 20, 1952	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Frederick		10c. City, Town or Location New Market	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6897 Meadow Point End		10f. Zip Code 21774		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Otis Edward Johnson				18. Mother's Name (First, Middle, Maiden Surname) Jane Carlie Lee			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Michael G. Bunitsky/Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6897 Meadow Point End, New Market, Maryland 21774			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem Gardens, Jan 6, 2000		20c. Location - City or Town, State Frederick, Maryland			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Kath Lynn Robinson M00706				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Sedative (Diphenhydramine) & Alcohol Overdose</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				Approximate Interval Between Onset and Death Hours			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hotel			
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) Dec 31, 1999		28b. Time of Injury 5:30a M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred victim ingested pills & alcohol		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) At Hotel		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5400 Holiday Drive Frederick, Maryland			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D35164		29d. Date signed (Month, Day, Year) December 31, 1999	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Zarick, Jr, M.D., 1080 West Patrick Street, Frederick, Maryland 21703							
	31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature A. Spaw...			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42583

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Gilbert Blades, Sr.

2. Date of Death
Month Day Year

December 23, 1999

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

217-14-4764

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Mar. 31, 1923

9. Birthplace (State or Foreign
Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Churchville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

701 Calvary Rd.

10f. Zip Code

21028

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?☒ Yes ☐ No
If Yes, Give
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Deputy Superintendent

16b. Kind of Business/Industry

State Police

17. Father's Name (First, Middle, Last)

Harry Charles Blades, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mae (nmn) Weimer

19a. Informant's Name/Relationship (Type, Print)

Sue A. Blades - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

701 Calvary Rd., Churchville, MD 21028

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Hillcrest Burial Park

Date

12-28-99

20c. Location - City or Town, State

Cumberland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. pneumonia, bilateral

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutrition, dehydration
encephalopathy, CVA. D.M
ASCVD

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☐ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D15152

29d. Date signed (Month, Day, Year)

12/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian T. Yeo, MD, 801 South Union Avenue, Havre de Grace, Maryland 21078

31. Date filed (Month, Day, Year)

DEC 29 1999

32. Registrar's Signature

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42584
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES ARNOLD BUSH				2. Date of Death Month December Day 19 Year 1999		3. Time of Death 1336
	4a. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston		4c. County of Death Harford
Funeral Director	5. Social Security Number 205-16-5297	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/28/1926	9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent						
10a. State Md.		10b. County Harford		10c. City, Town or Location Street		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 854 Federal Hill Road				10f. Zip Code 21154		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Heavy Equipment Operator		16b. Kind of Business/Industry Harford County Highways	
17. Father's Name (First, Middle, Last) David Ellsworth Bush				18. Mother's Name (First, Middle, Maiden Surname) Ella May Smith			
19a. Informant's Name/Relationship (Type, Print) Beverly Bush /Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 a,b,c,e,f			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) William Watters Cem.		20c. Location - City or Town, State 12/22 1999 Jarrettsville, Md.			
21. Signature of Funeral Service Licensee <i>M. Bladen Ruff</i>				22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ACUTE RESPIRATORY FAILURE							Approximate Interval Between Onset and Death 2 DAYS
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Andrew Nowakowski MD</i>				29c. License number D08096		29d. Date signed (Month, Day, Year) DECEMBER 19, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW NOWAKOWSKI MD 105 N. MAIN ST. BELAIR, MD 21014							
31. Date filed (Month, Day, Year) DEC 21 1999				32. Registrar's Signature <i>B. Spahr</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, #84

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

57

• • •

5050 1

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42585

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Jacob Crawford Briney

2. Date of Death

Dec. 19 1999

3. Time of Death

1115

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

5. Social Security Number

218-14-4201

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

09/28/1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3404 Old Level Road

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
6th

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Howard L. Briney

18. Mother's Name (First, Middle, Maiden Surname)

Emily Crawford

19a. Informant's Name/Relationship (Type, Print)

E. Rosalie B. Smith- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

514 Jo Ann Drive, Odenton, MD 21113

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rock Run Cemetery

Date

12/22/99

20c. Location - City or Town, State

Havre de Grace, MD

21. Signature of Funeral Service Licensee

Eugene M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.
123 S. Washington, Havre de Grace, MD 2107823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Lymphoma - non Hodgkin's
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure. CAD.
COPD.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy
performed?☐ Yes ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?☐ Yes ☒ No25. Was case referred to medical
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Eugene M. Smith MD

29c. License number

D 32609

29d. Date signed (Month, Day, Year)

12/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAMRUPIN MITHANI MD 703 Revolution St - Havre de Grace MD 21078

MD 21078

State
Registrar

31. Date filed (Month, Day, Year)

DEC 21 1999

32. Registrar's Signature

B. Smith

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42586

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michelle Marie Barron					2. Date of Death Month November Day 24 Year 1999		3. Time of Death 02:12 PM.			
	4a. Facility Name (If not institution, give street and number) 12301 Philadelphia Road					4b. City, Town, or Location of Death Bradshaw		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 215-80-0922		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 37 Yrs.		8. Date of Birth (Month, Day, Year) May 22, 1962		9. Birthplace (State or Foreign Country) New Jersey		
	Usual Residence of Decedent										
10a. State MD		10b. County Montgomery		10c. City, Town or Location Olney				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 3500 Toddsbury Lane					10f. Zip Code 20832		10g. Citizen of What Country? U.S.A.				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed			16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) Raymond G. O'Connell					18. Mother's Name (First, Middle, Maiden Surname) Neva A. Newton						
19a. Informant's Name/Relationship (Type, Print) Martha Bartley (Sister)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3500 Toddsbury Lane, Olney, Maryland 20832						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) R. a. Ferris & Co., Inc.			20c. Location - City or Town, State 12/18/99 West Chester, PA					
21. Signature of Funeral Service Licensee Kirsten Amy Unglesbee					22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UNDETERMINED Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) FOUND: 11-24-99		28b. Time of Injury FOUND: P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND: FIELD					28f. Location (Street and Number or Rural Route Number, City or Town, State) 12301 PHILADELPHIA ROAD BRADSHAW, MD						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Margarete M. Korell					29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) November 25, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) DEC 21 1999					32. Registrar's Signature B. Sparks						

99 42587

DMMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 99 42588

amend item 5 per informant G788 10/30/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Angela Brzostowski				2. Date of Death Month December Day 30 Year 1999				3. Time of Death 3 PM		
	4a. Facility Name (If not institution, give street and number) Copper Ridge Nursing Home				4b. City, Town, or Location of Death Sykesville				4c. County of Death Carroll Co.		
Funeral Director	5. Social Security Number 155-12-6986 155-22-6986		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) April 26, 1923		9. Birthplace (State or Foreign Country) New Jersey		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Carroll Co.		10c. City, Town or Location Sykesville				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 710 Obrecht Road				10f. Zip Code 21784				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Homemaker			
17. Father's Name (First, Middle, Last) John Bober				18. Mother's Name (First, Middle, Maiden Surname) Mary Szmulinski							
19a. Informant's Name/Relationship (Type, Print) Arthur Brzostowski				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Golden Rain Drive, Crofton, Md. 21114							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cemetery		Date Jan. 4, 2000		20c. Location - City or Town, State North Arlington, N.J.			
21. Signature of Funeral Service Licensee M-00849 <i>Paul T. Lochamp</i>				22. Name and Address of Facility Inman Nationwide 1605 Merwin Ave., Cleveland, OH. 44113							
23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Alzheimer Dementia Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 5 Yearrs	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Robert L. Moss, MD</i>				29c. License number D32882				29d. Date signed (Month, Day, Year) December 30, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Moss, MD, 114 Business Center Drive, Reisterstown, Md. 21136											
31. Date filed (Month, Day, Year) JAN 10 2000		32. Registrar's Signature <i>Benita G. Sparks</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42589

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Lewis David Burkholder		2. Date of Death Month Day Year DECEMBER 30, 1999		3. Time of Death 20:19 PM	
4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL			4b. City, Town, or Location of Death Hagerstown		4c. County of Death WASHINGTON
5. Social Security Number 213-72-7870	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) June 21 1956
9. Birthplace (State or Foreign Country) Maryland		Usual Residence of Decedent			
10a. State MD.	10b. County Washington	10c. City, Town or Location Clear Spring		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 14128 Spickler Rd.		10f. Zip Code 21722		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer	
16b. Kind of Business/Industry Agriculture		17. Father's Name (First, Middle, Last) Jacob H. Burkholder		18. Mother's Name (First, Middle, Maiden Surname) Emma E. Martin	
19a. Informant's Name/Relationship (Type, Print) Charlotte Burkholder/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14128 Spickler Rd. Clear Spring, Md. 21722			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Miller's Mennonite Church Cemetery		20c. Location - City or Town, State Leitersburg, Md.	
21. Signature of Funeral Service Licensee H. Martin Zimmerman Jr.		22. Name and Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225			
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ELECTROCUTION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Brief					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 12/30/99		28b. Time of Injury 7:30 P M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred WORKING ON ELECTRICAL APPLIANCE		28e. Location (Street and Number or Rural Route Number, City or Town, State) 14128 SPICKLER RD. CLEARSPRING, MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier J. M. Titus, M.D.		29c. License number OCME		29d. Date signed (Month, Day, Year) DECEMBER 31, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42590

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Janet Louise Christophel

2. Date of Death

December 30 1999 0015

Day Year

0015

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

168-36-9239

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 20, 1945

9. Birthplace (State or Foreign Country)

Penna.

Usual Residence of Decedent

10a. State

PA.

10b. County

Franklin

10c. City, Town or Location

Greencastle

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13587 Worleytown Rd.

10f. Zip Code

17225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Paul Dean Carbaugh

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Virginia Bingaman

19a. Informant's Name/Relationship (Type, Print)

Wayde L. Christophel Sr. / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13587 Worleytown Rd. Greencastle, Pa. 17225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Macedonia Church Cemetery 1/2/2000

Date

20c. Location - City or Town, State

Greencastle, Pa.

21. Signature of Funeral Service Licensee

H. Martin Zimmerman Jr.

22. Name and Address of Facility

Zimmerman And Son Funeral Home Inc.
45 S. Carlisle St. Greencastle, Pa. 17225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Lymphoma
Due to (or as a consequence of):

3 yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Neil O'Malley MD

29c. License number

D50813

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil O'Malley MD 11110 Medical Campus Rd Suite 127 Hagerstown, MD 21742

State
Registrar

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42591

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Beatrice Clayton				2. Date of Death Month Day Year December 26 1999		3. Time of Death 0409	
	4e. Facility Name (If not institution, give street and number) The Kent & Queen Anne's Hospital Inc.				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 218-16-5606	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-30-18	9. Birthplace (State or Foreign Country) Mo	
	Usual Residence of Decedent							
10a. State MO		10b. County KENT		10c. City, Town or Location CHESTERTOWN			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 402 MORGNEC RD. APT 5-C				10f. Zip Code 21620		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook			16b. Kind of Business/Industry DOMESTIC	
17. Father's Name (First, Middle, Last) HARRY THOMAS FOREMAN				18. Mother's Name (First, Middle, Maiden Surname) HARRIET REBECCA THOMAS				
19a. Informant's Name/Relationship (Type, Print) MRS. BARBARA KENNEDY. DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 292. CHESTERTOWN, MD 21620				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) EMMANUEL U. M. Cem.		Date 12-30-99		20c. Location - City or Town, State POMONA, MD
21. Signature of Funeral Service Licensee Joyce O. Waller				22. Name and Address of Facility WALLER FUNERAL HOME. CHESTERTOWN, MD 21620				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardiogenic shock Due to (or as a consequence of): b. Anterior, inferior myocardial infarction Due to (or as a consequence of): c. Acute renal failure Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 36 hrs. 48 hrs. 24 hrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes, hypercholesterolemia, atherosclerotic coronary artery disease								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier MD				29c. License number D51735		29d. Date signed (Month, Day, Year) 12/26/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick De Vroy, MD 6602 Church Hill Rd. Chestertown, Md 21620								
31. Date filed (Month, Day, Year) DEC 29 1999				32. Registrar's Signature Benjamin G. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42592

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Mae Cooper

2. Date of Death

December 27, 1999

3. Time of Death

8:45 P.M.

4a. Facility Name (If not institution, give street and number)

601 Cornell Street Apt. 100

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

215-34-6054

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 28, 1922

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

601 Cornell Street Apt. 100

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

In home

17. Father's Name (First, Middle, Last)

Everett Mines

18. Mother's Name (First, Middle, Maiden Surname)

Mae UNK

19a. Informant's Name/Relationship (Type, Print)

Albert K. Cooper, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

723 Sequoia Drive, Edgewood, Maryland 21040

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

12/30/99

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Kenneth B. Cays

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypertensive Arteriosclerotic Cardiovascular Disease > 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive airways disease

Schizophrenia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Claudia A. Krohn MD

29c. License number

D50040

29d. Date signed (Month, Day, Year)

12-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1308 Business Center Way #103, Edgewood MD 21040

31. Date filed (Month, Day, Year)

DEC 29 1999

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42593

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH MARY CIARPELLA

2. Date of Death

Month Day Year
DEC 30 1999

3. Time of Death

11:47 AM

4a. Facility Name (If not institution, give street and number)

ER FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral
Director

5. Social Security Number

216-24-1490

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 28, 1923

9. Birthplace (State or Foreign Country)

Ireland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1018 Vale Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

U/K

U/K

Carr

18. Mother's Name (First, Middle, Maiden Surname)

U/K

U/K

U/K

19a. Informant's Name/Relationship (Type, Print)

Theresa Ciarpella - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1018 Vale Road, Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Highview Memorial Gardens 1/3/2000

Date

20c. Location - City or Town, State

Fallston, MD

21. Signature of Funeral Service Licensee

Helly K. McComas

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

G. M. E. O. C. M. E.

29c. License number

12-30-1999

29d. Date signed (Month, Day, Year)

12-30-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. M. E. M. D. 218 W. 1st AVE BELAIR MD 21014

State
Registrar

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

Denise B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42594

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Lynwood Critzer

2. Date of Death

Month

Day

Year

December 26 1999

3. Time of Death

0200

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

225-32-8691

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 22, 1931

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1208 St. Francis Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Korean13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Field Supervisor

16b. Kind of Business/Industry

Traffic Engineering

17. Father's Name (First, Middle, Last)

Thomas Spotswood Critzer

18. Mother's Name (First, Middle, Maiden Surname)

Lula Ann Drumheller

19a. Informant's Name/Relationship (Type, Print)

Peggie Watson Critzer/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1208 St. Francis Road, Bel Air, MD 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Bel Air Memorial Gardens 12/28/99 Bel Air, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Stephan A. Hughes

22. Name and Address of Facility

McComas Funeral Home, P.A.
50 West Broadway Street, Bel Air, MD 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 years

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Gastrointestinal bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kevin R. Snyder MD

29c. License number

D33642

29d. Date signed (Month, Day, Year)

December 26, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kevin C. Snyder MD 754 Hickory Ave Bel Air MD 21014

31. Date filed (Month, Day, Year)

DEC 27 1999

32. Registrar's Signature

Shirley G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerDivision of Vital Records, P.O. Box 68760,
CITIZENSHIPTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2011

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42595

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BLANCA RUBIA CEA					2. Date of Death Month Day Year DEC. 30, 1999		3. Time of Death 1445	
	4a. Facility Name (If not institution, give street and number) 1405 Grouse Court					4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 228-31-5399	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-31-1940		9. Birthplace (State or Foreign Country) El Salvador	
	Usual Residence of Decedent								
10a. State MD		10b. County Frederick		10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 1405 Grouse Court				10f. Zip Code 21703		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Salvadoria			14. Race - American Indian, Black, White, etc. Specify: Hispanic		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Homemaker		
17. Father's Name (First, Middle, Last) Eugenio Flores					18. Mother's Name (First, Middle, Maiden Surname) Enor Maria Jaime				
19a. Informant's Name/Relationship (Type, Print) Wilfredo Garcia (Son-In-Law)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Bishops Glen Drive Frederick, Md. 21702				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 1/2/2000		20c. Location - City or Town, State Smithsburg, MD.		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD. 21701				
23a. Part I. Enter the disease, or condition, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or asphyxia. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LEIOMYOSARCOMA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred					28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 					29c. License number D43809		29d. Date signed (Month, Day, Year) Jan. 1, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neeta Ahuja, MD 201 North Washington Street Falls Church, VA. 22076									
31. Date filed (Month, Day, Year) JAN 03 2000					32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42596

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roy Wesley Cutsail, Jr.				2. Date of Death Month Day Year December 30, 1999		3. Time of Death 12:40 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Health Care Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 218-12-7969		6. Sex XXM 2□F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) March 9, 1924	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1XX Yes 2□ No				10e. Street and Number 628 Wilson Place		10f. Zip Code 21702	
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1□ Never Married 2□ Married 3XX Widowed 4□ Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1□ Yes 2XX No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2XX No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman/Carpenter				16b. Kind of Business/Industry Construction			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Roy Wesley Cutsail, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Maude Lee Waltz			
	19a. Informant's Name/Relationship (Type, Print) Mrs. Sylvia A. Chapman, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10302 Caspian Way, New Market, Md. 21774			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1XX Burial 2□ Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Jan. 4, 2000		20c. Location - City or Town, State Frederick, Maryland	
	21. Signature of Funeral Service Licensee Richard E. Graf MO0255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COPD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DVT, cardiomyopathy, diabetes renal insufficiency, normal pressure hydrocephalus							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1□ Yes 2□ No 3□ Probably 4□ Unknown							24b. Were autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No
	24a. Was an autopsy performed? 1□ Yes 2□ No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1□ Yes 2□ No				26. Place of Death (Check only one) Hospital: 1□ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4□ Nursing Home 5□ Residence 6□ Other (Specify)			
	27. Manner of Death 1□ Natural 2□ Accident 3□ Suicide 4□ Homicide 5□ Pending investigation 6□ Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? 1□ Yes 2□ No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1□ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) December 30, 1999
	29b. Signature and title of certifier Katherine Buki				29c. License number D0054705			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine Buki 300 West 9th Street Frederick MD 21701							31. Date filed (Month, Day, Year) JAN 03 2000
	32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42597

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Fred Vincent Cornwell				2. Date of Death Month Day Year December 23, 1999		3. Time of Death 9:45 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 042-18-0477	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov. 3, 1921	9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 2629 Caulfield Court			10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Car Manager		16b. Kind of Business/Industry Automobile Dealership			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Fred Vincent Cornwell			18. Mother's Name (First, Middle, Maiden Surname) Dorothy Elizabeth Bevans				
	19a. Informant's Name/Relationship (Type, Print) Mrs. Cindy Gallaway, daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8520 Inspiration Ave., Walkersville, Md. 21793				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Marys Church Cem., Dec. 28, 1999		20c. Location - City or Town, State Petersville, Md.			
	21. Signature of Funeral Service Licensee Richard E. [Signature] M00255		22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End-stage Chronic Obstructive Lung Disease 18 years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Heart Disease, 2/98						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
State Registrar	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29c. License number D21944	
	29b. Signature and title of certifier [Signature]			29d. Date signed (Month, Day, Year) 12/24/99		29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) James S. Grissom, 300 W. 9th St. Frederick, Md 21701		
31. Date filed (Month, Day, Year) DEC 27 1999		32. Registrar's Signature [Signature]						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42598

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey Bolton Ciucci

2. Date of Death

Dec. 20, 1999 Year

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

Northampton Manor Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

229-03-7747

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 21, 1920

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

VA.

10b. County

None

10c. City, Town or Location

Richmond

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1713 Bellevue Ave.

10f. Zip Code

23227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

assembly person

16b. Kind of Business/Industry

mfg. co.

17. Father's Name (First, Middle, Last)

Benjamin Thomas Bolton

18. Mother's Name (First, Middle, Maiden Surname)

Annie Mae Miller

19a. Informant's Name/Relationship (Type, Print)

Carole M. Gropl (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Hamburg, Germany

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Lawn Cemetery

Date

12/23

20c. Location - City or Town, State

Henrico, VA.

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *metastatic adenocarcinoma of lung months*
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Brain metastases

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

026499

29d. Date signed (Month, Day, Year)

12-21-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. RONALD MILLER POB 210 MT. AIRY RD 21771

State
Registrar

31. Date filed (Month, Day, Year)

DEC 27 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

#10b per GP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42599

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VITOLIS ANTHONY DUOBLYS				2. Date of Death Month Day Year DECEMBER 18, 1999		3. Time of Death 10:34 AM	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
Funeral Director	5. Social Security Number 324-32-5014		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 6, 1938	
	9. Birthplace (State or Foreign Country) Lithuania		10a. State Maryland		10b. County Harford		10c. City, Town or Location Havre de Grace	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1925 Chapel Road		10f. Zip Code 21078		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1957-81		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Model Maker		16b. Kind of Business/Industry U.S. Government				
17. Father's Name (First, Middle, Last) Joseph (u/k) Duoblys				18. Mother's Name (First, Middle, Maiden Summa) Adele (u/k) Budzys				
19a. Informant's Name/Relationship (Type, Print) Ok Soon Duoblys / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1925 Chapel Road, Havre de Grace, Maryland 21078				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Gardens		20c. Location - City or Town, State 12-22-99 Aberdeen, Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McComas Funeral Home, P.A.		22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of): b. Myeloma - Plasmacytoma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? N/A <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 12-22-99		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D0018629		
29d. Date signed (Month, Day, Year) December 20, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rafiq Patel, MD 1952 Pulaski Hwy, Edgewood, MD 21040		31. Date filed (Month, Day, Year) DEC 21 1999		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42600

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN PATRICIA DAVIS

2. Date of Death

December 23, 1999

3. Time of Death

10:35 P.M.

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

220-34-7139

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 28, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6 Aberdeen Avenue

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ernest Leslie Epperley

18. Mother's Name (First, Middle, Maiden Surname)

Clara Mae Scarborough

19a. Informant's Name/Relationship (Type, Print)

Felix T. Davis, Sr. - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Aberdeen Avenue, Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Baker's Cemetery

Date

12/28/99

20c. Location - City or Town, State

Aberdeen, MD

21. Signature of Funeral Service Licensee

Charles A. Emge

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiorespiratory Failure

Due to (or as a consequence of):

b. Coronary artery disease

Due to (or as a consequence of):

c. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

P20661

29d. Date signed (Month, Day, Year)

12/24/99

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

Lee M.D. 669 Revolution St. Havre de Grace MD 21078

31. Date filled (Month, Day, Year)

DEC 27 1999

32. Registrar's Signature

B. Spade

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, VE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42601

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Maude Dill

2. Date of Death

December 26, 1999

3. Time of Death

12:46 AM

4a. Facility Name (If not institution, give street and number)

Reeder's Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

218-50-3717

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 28, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Jefferson

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3819 Jefferson Pike

10f. Zip Code

21755

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

self

16b. Kind of Business/Industry

homemaker

17. Father's Name (First, Middle, Last)

Olie Burr Duvall

18. Mother's Name (First, Middle, Maiden Surname)

Nettie Hammond Etchison

19a. Informant's Name/Relationship (Type, Print)

Bettye Herrell, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3819 Jefferson Pike, Jefferson, Maryland 21755

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

12/29/99

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

Ryan M. Buyer M00999

22. Name and Address of Facility

Keeney and Basford Funeral Home
106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RENAL FAILURE

Due to (or as a consequence of):

since 7/22/99

c. SUBDURAL HEMATOMA

Due to (or as a consequence of):

since 7/22/99

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Waseem M. Khalid

29c. License number

D 52323

29d. Date signed (Month, Day, Year)

12/26/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Waseem M. Khalid, M.D. 10148 St. George Circle Hagerstown, Maryland 301-739-3750

31. Date filed (Month, Day, Year)

DEC 28 1999

32. Registrar's Signature

B. Sparks

State
Registrar

NAME: DILL, MARGARET MAUDE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42602

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SISTER MARIE JULIE DONOHUE				2. Date of Death Month: DECEMBER Day: 24, Year: 1999		3. Time of Death 2:55 A.M.	
	4a. Facility Name (If not Institution, give street and number) ST. CATHERINE'S NURSING CENTER				4b. City, Town, or Location of Death EMMITSBURG		4c. County of Death FREDERICK	
Funeral Director	5. Social Security Number 220-54-6872		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 101 Yrs.		8. Date of Birth (Month, Day, Year) MAR. 13, 1898	
	9. Birthplace (State or Foreign Country) WORCESTER, MA		10a. State MARYLAND		10b. County FREDERICK		10c. City, Town or Location EMMITSBURG	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 331 S. SETON AVE.		10f. Zip Code 21727	
	10g. Citizen of What Country? U. S. A.				11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER		16b. Kind of Business/Industry SISTER OF NOTRE DAME	
	17. Father's Name (First, Middle, Last) TIMOTHY DONOHUE				18. Mother's Name (First, Middle, Maiden Surname) JULIA LYNCH			
	19a. Informant's Name/Relationship (Type, Print) SR. MARY ADELE WHITE/SUPERIOR				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 331 S. SETON AVE., EMMITSBURG, MD. 21727			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SISTERS OF NOTRE DAME		20c. Location - City or Town, State ELLCOTT CITY, MD.	
	21. Signature of Funeral Service Licensee <i>John M. Stakes</i>				22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Pneumonia - aspiration</i> b. <i>Alzheimer's Dementia</i> c. <i>Atherosclerosis</i> d.				Approximate Interval Between Onset and Death <i>7 weeks</i>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Bonita Oprea</i>				
29c. License number H47037				29d. Date signed (Month, Day, Year) DECEMBER 24, 1999				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 52 Water Street Thurmont, MD 21727				31. Date filed (Month, Day, Year) DEC 27 1999				
32. Registrar's Signature <i>B. Smith</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42603

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELIZABETH ANNE ELIASON				2. Date of Death Month 12 Day 27 Year 99		3. Time of Death 0457	
	4a. Facility Name (If not Institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 215-26-2510	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) December 24, 1929		9. Birthplace (State or Foreign Country) Chestertown, MD
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Kent	10c. City, Town or Location Chestertown			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 10222 Fairlee Farm Lane				10f. Zip Code 21620		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home			
	17. Father's Name (First, Middle, Last) Spencer Smith				18. Mother's Name (First, Middle, Maiden Surname) Ella Davis			
	19a. Informant's Name/Relationship (Type, Print) Walker C. Eliason/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10222 Fairlee Farm Lane, PO Box 870, Chestertown, Maryland 21620			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chester Cemetery		20c. Location - City or Town, State 1/3/2000 Chestertown, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiogenic Shock</u> Due to (or as a consequence of): b. <u>Acute Renal failure</u> Due to (or as a consequence of): c. <u>Atherosclerotic coronary artery disease</u> Due to (or as a consequence of): d. <u>Coronary artery bypass graft</u>				Approximate Interval Between Onset and Death 48 hrs. 36 hrs. 1 yr. 2 months			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Morbid obesity, hypertension</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier MD		29c. License number D51735		29d. Date signed (Month, Day, Year) 12/28/99
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK DELANY, MD 6602 CHURCH HILL RD, CHESTERTOWN MD 21620								
31. Date filed (Month, Day, Year) DEC 29 1999				32. Registrar's Signature 				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42604

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William J. Elias					2. Date of Death Month Day Year December 23, 1999		3. Time of Death 8:09 AM		
	4a. Facility Name (If not institution, give street and number) VA Maryland Health Care System					4b. City, Town, or Location of Death Perry Point		4c. County of Death Cecil		
Funeral Director	5. Social Security Number 215-26-5053		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Mar. 17, 1923		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent					10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. State MD		10b. County Kent		10c. City, Town or Location Chestertown						
10e. Street and Number 24745 Langford Road					10f. Zip Code 21620			10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943 1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)					16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) William Elias					18. Mother's Name (First, Middle, Maiden Surname) Eleanor Tilghman					
19a. Informant's Name/Relationship (Type, Print) Doris Brown, Caretaker					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24745 Langford Rd., Chestertown, MD 21620					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Pleasant Cemetery		Date 12/27/99		20c. Location - City or Town, State Fairlee, MD			
21. Signature of Funeral Service Licensee <i>James A. Perkins</i>					22. Name and Address of Facility James A. Perkins Funeral Service 21106 Rock Hall Ave., Rock Hall, MD 21661					
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last e. Cancer of Esophagus Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death 6 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Ken Ken Leung M.D.</i>					29c. License number D16608			29d. Date signed (Month, Day, Year) December 23, 1999		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KAM KEN LEUNG, M.D., VA Maryland Health Care System, Perry Point, MD 21902										
31. Date filed (Month, Day, Year) DEC 27 1999					32. Registrar's Signature <i>Benjamin B. Sparks</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

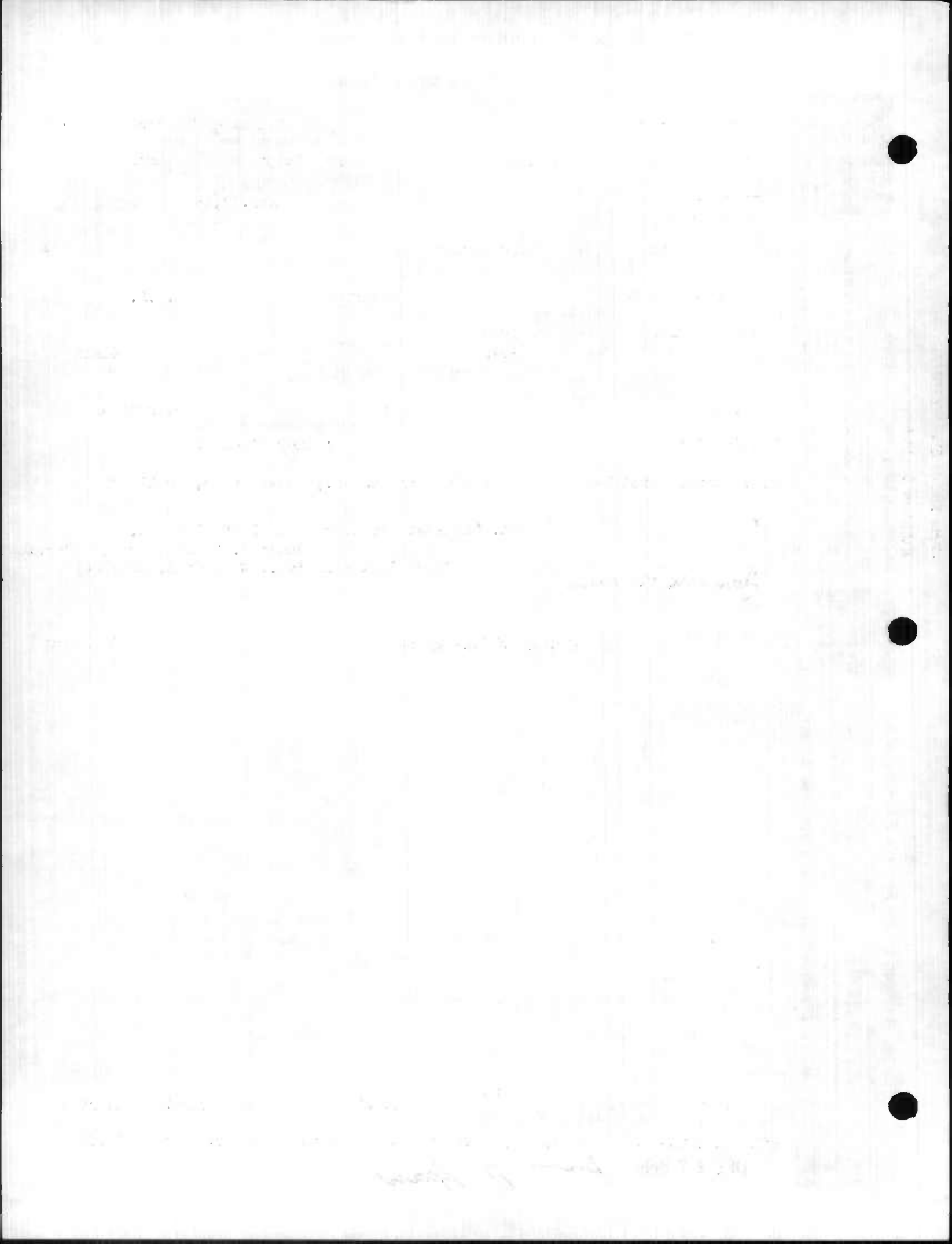
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME KNOWN TO PHYSICIAN:

WILLIAM J. ELIAS
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42605

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH PAULA ELLIOTT

2. Date of Death

Month
12Day
22Year
99

3. Time of Death

3:45 AM

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

212-20-8617

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
08/22/1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre de Grace

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

301 Strawberry Lane Apt 2

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Stock Person

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Ernest Verille

18. Mother's Name (First, Middle, Maiden Surname)

Doquitzia Marte

19a. Informant's Name/Relationship (Type, Print)

Dominic Verille- Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1407 Superior St., Havre de Grace, MD 21078

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris & Co. Inc.

Date

12/23/99

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Dwayne M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.
123 S. Washington, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Generalized Arteriosclerosis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 yrs.

5 yrs.

10 yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Pneumonia

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dwayne M. Smith M.D.

29c. License number

D-15994

29d. Date signed (Month, Day, Year)

12-22-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LETICIA S. GALVEZ, M.D. 625 S. UNION AVE. HAVRE DE GRACE, MD.

State
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1999

32. Registrar's Signature

Dwayne M. Smith

21078

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

ELIZABETH ELLIOTT 12/22/99 03:45

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42606

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Small

Eckert

2. Date of Death

Month Day, 1999 Year

Dec. 24, 1999

3. Time of Death

4:20 AM

4a. Facility Name (If not institution, give street and number)

4494 Pinewood Trail

4b. City, Town, or Location of Death

Middletown

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

232-01-8802

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day, 1920 Year

Jan. 19, 1920

9. Birthplace (State or Foreign Country)

W. VA.

Usual Residence of Decedent

10a. State

MD.

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4494 Pinewood Trail

10f. Zip Code

21769

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Omar H. Small

18. Mother's Name (First, Middle, Maiden Surname)

Grace Mong

19a. Informant's Name/Relationship (Type, Print)

Cleo L. Eckert (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4494 Pinewood Trail, Middletown, MD. 21769

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Lutheran Cemetery

Date

12/28

20c. Location - City or Town, State

Middletown, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home

31 E. Main St., Middletown, MD. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Lymphoma
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death4 mos.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
Investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-13971.

29d. Date signed (Month, Day, Year)

12/27/99.

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

300 W 9th St, Frederick, MD 21701

31. Date filed (Month, Day, Year)

DEC 29 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42607

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUIS MARTIN FRIESS				2. Date of Death Month December Day 31 , Year 1999		3. Time of Death 1:26 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 215-38-5094	6. Sex 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) Oct. 3, 1941	9. Birthplace (State or Foreign Country) D.C.	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 102 Dogwood Avenue				10f. Zip Code 21788		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Trucking		
17. Father's Name (First, Middle, Last) Adam L. Friess				18. Mother's Name (First, Middle, Maiden Surname) Minnie May Pier				
19a. Informant's Name/Relationship (Type, Print) Patty A. Friess (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Dogwood Avenue, Thurmont, Maryland 21788				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Blue Ridge Cemetery		Date 1/4/2000		20c. Location - City or Town, State Thurmont, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET, THURMONT, MD 21788				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A.S.C.V.D. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death years.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D35164		29d. Date signed (Month, Day, Year) January 4, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Zarick, MD Rt. 40 1080 West Patrick Street, Frederick, MD 21702								
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-535-2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42608

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marguerite G. Flanigan				2. Date of Death Month: December Day: 26, Year: 1999				3. Time of Death 10:20	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-50-7585		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 8, 1906		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Keymar				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 11629 Haughs Church Road				10f. Zip Code 21757		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Joseph Grover Cleveland Marshall				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Sarah Forney					
	19a. Informant's Name/Relationship (Type, Print) Arthur A. Flanigan, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10018 Rocky Ridge Road, Rock Ridge, Maryland 21778					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wellers U.M.C. Cemetery		Date Dec 29 1999		20c. Location - City or Town, State Thurmont, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 E. Main Street Thurmont, Maryland 21788					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>pneumonia</u> Due to (or as a consequence of):								Approximate Interval Between Onset and Death 10 d	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>congestive heart failure</u>									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D0031058		29d. Date signed (Month, Day, Year) 12/27/99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene F. Ash 10200 Coppertown Rd, Woodbury, MD 21798									
	31. Date filed (Month, Day, Year) DEC 30 1999		32. Registrar's Signature 							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42609
Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Turner Furr				2. Date of Death Month December Day 24 , Year 1999				3. Time of Death 7:47 PM	
4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
5. Social Security Number 229-32-8186		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 7, 1929		9. Birthplace (State or Foreign Country) Virginia	
Usual Residence of Decedent									
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 17060 King James Way				10f. Zip Code 20877		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber			16b. Kind of Business/Industry Plumbing		
17. Father's Name (First, Middle, Last) Lawrence Richard Furr				18. Mother's Name (First, Middle, Maiden Surname) Mary Bellar					
19a. Informant's Name/Relationship (Type, Print) Susana Butt - Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13741 Travilah Road, Rockville, Maryland 20850					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Monocacy Cemetery		Date 12/29/99		20c. Location - City or Town, State Beallsville, Maryland			
21. Signature of Funeral Service Licensee Robert L. Williams				22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)				e. Acute Myocardial Infarction				Approximate Interval Between Onset and Death Minutes	
				Due to (or as a consequence of):					
				b. Coronary Artery Disease				Years	
				Due to (or as a consequence of):					
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				c.					
				Due to (or as a consequence of):					
				d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier. Thai McGreivey M.D.				29c. License number D47093		29d. Date signed (Month, Day, Year) December 28, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thai McGreivey, M.D. SGAH - 9501 Medical Center Drive, Rockville, Maryland								20850	
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature B. Sparks							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42610

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louis Ceasar Ganzzermiller

2. Date of Death

December 29, 1999

3. Time of Death

5:50 A

4a. Facility Name (If not institution, give street and number)

Levindale Hebrew Geriatric Center

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

217-18-0113

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03/04/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Cecil

10c. City, Town or Location

Perryville

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

143 Bayscape Drive

10f. Zip Code

21903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 1945-47

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 4th College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

Joseph Ganzzermiller

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Yoss

19a. Informant's Name/Relationship (Type, Print)

Sadie M. Ganzzermiller- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

143 Bayscape Dr., Perryville, MD 21903

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Grd 12/31/99 Cockeysville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Spaine M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.
123 S. Washington, Havre de Grace, MD 21078

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer, Adenocarcinoma
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Debra S Wertheimer MD

29c. License number

D23767

29d. Date signed (Month, Day, Year)

December 29, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debra S Wertheimer MD, 2434 W. Belvedere Ave, Balto. MD 21215

31. Date filed (Month, Day, Year)

Dec 30 1999

32. Registrar's Signature

A. Sparks

State
Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, SK

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42611

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAUL B. GANLEY				2. Date of Death Month Day Year December 22, 1999		3. Time of Death 6:00 P.M.		
	4a. Facility Name (If not institution, give street and number) 6140 Longbranch Road				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 217-12-1864		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) April 30, 1919		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6140 Longbranch Rd.		10f. Zip Code 21701		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: W.W.II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Realtor		16b. Kind of Business/Industry Real-estate		17. Father's Name (First, Middle, Last) Joseph Hickman Ganley		18. Mother's Name (First, Middle, Maiden Surname) Virgi Knott	
19a. Informant's Name/Relationship (Type, Print) Beverly Ganley / wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6140 Longbranch Rd. / Frederick, MD 21701		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Location - City or Town, State 12-24-99 Frederick, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike / Frederick, MD 21702		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. LIVER FAILURE Due to (or as a consequence of): b. ALCOHOLIC CIRRHOSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 5 YRS 10 YRS			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 39846		29d. Date signed (Month, Day, Year) 12/23/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEAN HUNT MD 310 W. NINTH ST FREDERICK, MD 21701		31. Date filed (Month, Day, Year) DEC 27 1999		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42612

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Virginia Susan Hart				2. Date of Death Month Day Year December 31 1999		3. Time of Death 1902								
	4a. Facility Name (If not institution, give street and number) Washington County Hospital				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington								
Funeral Director	5. Social Security Number 214-09-0948	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 14, 1918	9. Birthplace (State or Foreign Country) Maryland								
	Usual Residence of Decedent														
10a. State Md.		10b. County Washington		10c. City, Town or Location Hagerstown		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
10e. Street and Number 725 Interval Rd.				10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White									
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Office Work		16b. Kind of Business/Industry Catalog Co.									
17. Father's Name (First, Middle, Last) Dwight D. Dunkel				18. Mother's Name (First, Middle, Maiden Surname) Leah Belle Foutz											
19a. Informant's Name/Relationship (Type, Print) Lynda S. Socks (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21918 Jefferson Blvd. Smithsburg, Md. 21783											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory Jan. 3, 2000		20c. Date 3, 2000		20d. Location - City or Town, State Smithsburg, Md.									
21. Signature of Funeral Service Licensee <i>Dennis L. Sparks</i>				22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> { </td> <td>a. <u>Acute Myocardial Infarction</u></td> <td rowspan="4"> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ </td> <td rowspan="4"> Approximate Interval Between Onset and Death <u>sudden</u> </td> </tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. <u>Acute Myocardial Infarction</u>	Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	Approximate Interval Between Onset and Death <u>sudden</u>			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. <u>Acute Myocardial Infarction</u>	Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____	Approximate Interval Between Onset and Death <u>sudden</u>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
		28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <i>Dino J. Delaportas</i>				29c. License number D 26523		29d. Date signed (Month, Day, Year) 1/1/00									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Dino J. Delaportas MD 11110 Medical Campus Road Hagerstown MD 21742</i>															
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature <i>Dennis L. Sparks</i>													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42613

Amended #4a, 1/3/00, CWC, Kent County

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Willing Huber			2. Date of Death Month Day Year December 30 1999		3. Time of Death 2145	
	4a. Facility Name (If not institution, give street and number) The Kent and Queen Anne's Hospital Inc. 201 Water Street			4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 180-16-8387		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) May 22, 1924
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) Pennsylvania				
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street end Number 201 N. Water Street			10f. Zip Code 21620		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: X		14. Race - American Indian, Black, White, etc. Specify: white
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Antique / Decorating		16b. Kind of Business/Industry Antique		
Physician /Medical Examiner	17. Father's Name (First, Middle, Last) Joel Cook Huber			18. Mother's Name (First, Middle, Maiden Surname) Mary Hays			
	19a. Informant's Name/Relationship (Type, Print) Mary Savage Huber			19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 201 N. Water St. Chestertown, Md. 21620			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Cremation Cntr. 12/31		20c. Location - City or Town, State Stevensville, Md.		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Fellows, Helfenbein, and Newnam Funeral Hm. 130 Speer Rd. Chestertown, Md. 21620 778-0055				
Physician /Medical Examiner	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gun Shot Wound to Head Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death < 1 sec
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. History of Major Depression Chronic Obstructive Pulmonary Disease Atrial Fibrillation and flutter						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 12/30/99		28b. Time of Injury 8:15 PM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred Gun Shot Wound to Head		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home: Garage				
	28f. Location (Street and Number or Rural Route Number, City or Town, State) Chestertown MD @ Home						
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D0051786		29d. Date signed (Month, Day, Year) 12/31/99
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ferguson - 120 Speer Road Chestertown MD 21620						
	31. Date filed (Month, Day, Year) JAN 3 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42614

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Ruth Hannold

2. Date of Death

December 27, 1999

3. Time of Death

9:25 a.m.

4a. Facility Name (If not institution, give street and number)

Heron Point

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

142-36-6874

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 9, 1907

9. Birthplace (State or Foreign Country)

Baltimore, Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10003 Heron Point

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Ownhome

17. Father's Name (First, Middle, Last)

Charles S. Holt

18. Mother's Name (First, Middle, Maiden Surname)

Bertie Ford

19a. Informant's Name/Relationship (Type, Print)

Mary Ruth Talley/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19 Mantua Road, Mt. Royal, NJ 08061

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Eglington Cemetery

Date

12/30/99

20c. Location - City or Town, State

Clarksboro, New Jersey

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newman Funeral Home, P.A.

130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOPOROSIS WITH KNEE FRACTURE

SEVERE OSTEOARTHRITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 41587

29d. Date signed (Month, Day, Year)

12/27/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

12 Helen A. Noble 122 Speer Road, Suite 5, Chestertown, MD 21620

31. Date filed (Month, Day, Year)

DEC 28 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Handwritten text, possibly a signature or name, located in the upper middle section of the page.

Handwritten text, possibly a date or reference number, located in the middle section of the page.

Handwritten text, possibly a title or subject line, located in the lower middle section of the page.

Handwritten text, possibly a date or reference number, located in the bottom left corner.

Handwritten text, possibly a date or reference number, located in the bottom middle section.

Handwritten text, possibly a name or signature, located in the bottom right section.

Handwritten text, possibly a date or reference number, located at the very bottom of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42615

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Texie (nmn) Holloway				2. Date of Death Month December Day 21 , Year 1999				3. Time of Death 11:53 PM	
	4a. Facility Name (If not institution, give street and number) 911 Pine Road				4b. City, Town, or Location of Death Joppa				4c. County of Death Harford	
Funeral Director	5. Social Security Number 212-28-0416		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 26, 1907		9. Birthplace (State or Foreign Country) N. Carolina	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Harford		10c. City, Town or Location Joppa				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 911 Pine Road				10f. Zip Code 21085				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Henry (nmn) Casey				18. Mother's Name (First, Middle, Maiden Surname) Harriet (nmn) (unknown)						
19a. Informant's Name/Relationship (Type, Print) Sylvia Day/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Pine Road, Joppa, MD 21085						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens 12-23-99 Bel Air, Maryland				20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASCVD ARTERIO SCLEROTIC Due to (or as a consequence of): CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier DME				29c. License number OCME		
				29d. Date signed (Month, Day, Year) DEC 22 1999						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 PRA BHO M-D 218 FOLFORD AVE BELAIR MD 21014										
31. Date filed (Month, Day, Year) DEC 27 1999				32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

m

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42616

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel Rogers Hopkins

2. Date of Death

Month
Dec.Day
24Year
1999

3. Time of Death

4:12am

4a. Facility Name (If not institution, give street and number)

Hart Heritage

4b. City, Town, or Location of Death

Street

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

213-36-8996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

02/17/1905

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Darlington

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

833 Priestford Road

10f. Zip Code

21034

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Lester Rogers

18. Mother's Name (First, Middle, Maiden Surname)

Dora Jones

19a. Informant's Name/Relationship (Type, Print)

Harry G. Hopkins- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

833 Priestford Road, Darlington, MD 21034

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Spesutia Cemetery

Date

12/28/99

20c. Location - City or Town, State

Perryman, MD

21. Signature of Funeral Service Licensee

Mitchell M. Smith

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.

123 S. Washington, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute Pulmonary Edema*

Due to (or as a consequence of):

b. *Ischemic Coronary Disease.*

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Kevin Lynch

29c. License number

D 35072

29d. Date signed (Month, Day, Year)

DECEMBER 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Kevin Lynch MD 2 North Ave. Bel Air, Md. 21014

31. Date filed (Month, Day, Year)

DEC 27 1999

32. Registrar's Signature

*B. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42617

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Louise Hameyer				2. Date of Death Month December Day 23 , Year 1999		3. Time of Death 9:00 AM	
	4a. Facility Name (If not institution, give street and number) 5934 Serenity Lane				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 220-20-7414		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 2, 1912	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5934 Serenity Lane		10f. Zip Code 20855		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) William H. Lomyer				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Suzanne Venzke			
	19a. Informant's Name/Relationship (Type, Print) Patsy H. Herberg/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5934 Serenity Lane, Rockville, MD 20855			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Lutheran Cem.		20c. Location - City or Town, State 12/29/99 Joppa, Maryland			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D08381		29d. Date signed (Month, Day, Year) December 23, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Avrunin, M.D., 18111 Prince Philip Dr., #209, Olney, Maryland 20832							
	31. Date filed (Month, Day, Year) DEC 27 1999				32. Registrar's Signature 			
	State Registrar							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42618

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Inez Rebecca Holland			2. Date of Death Month Day Year Dec 31 1999		3. Time of Death 12:50 PM	
	4a. Facility Name (If not institution, give street and number) Genesis ElderCare - The Pines			4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 220-10-5395		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	8. Date of Birth (Month, Day, Year) Oct 17, 1910		9. Birthplace (State or Foreign Country) Mount Airy, MD
	Usual Residence of Decedent						
10a. State Maryland		10b. County Talbot		10c. City, Town or Location Easton		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 8176 Ethan Avenue				10f. Zip Code 21601		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+) 6				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Edward Watkins				18. Mother's Name (First, Middle, Maiden Surname) Bertha Condon			
19a. Informant's Name/Relationship (Type, Print) Gloria I. Finn/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8176 Ethan Avenue, Easton, Maryland 21601			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet Cemetery Jan 5, 2000		Date Jan 5, 2000		20c. Location - City or Town, State Frederick, Maryland	
21. Signature of Funeral Service Licensee <i>Keeney & Basford</i> M00706				22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701			
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Urosepsis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <i>weeks</i>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dehydration</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>DZS933</i>		29d. Date signed (Month, Day, Year) <i>12.31.99</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>MICHAEL CROWLEY, MD 508 IDLEWILD AVENUE EASTON, MD 21601</i>							
31. Date filed (Month, Day, Year) <i>JAN 03 2000</i>		32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Inez Holland
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42619

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ALICE J. HURLEY				2. Date of Death Month Day Year December 31, 1999		3. Time of Death 2:40 PM	
	4a. Facility Name (If not institution, give street and number) 5249 A, Wigville Rd.				4b. City, Town, or Location of Death Thurmont		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 215-34-3523	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 15, 1934		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5249 A, Wigville Road				10f. Zip Code 21788		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry self		
17. Father's Name (First, Middle, Last) John W. Cool				18. Mother's Name (First, Middle, Maiden Surname) Mary Alice Riley				
19a. Informant's Name/Relationship (Type, Print) Alan Hurley / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10605 Rocky Ridge Rd., Rocky Ridge, MD 21778				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens		Date 1/4/00		20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Stauffer Funeral Home 104 E. Main Street, Thurmont, MD 21788				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Severe obliterating vascular disease</i> Due to (or as a consequence of): b. <i>Hypertension</i> Due to (or as a consequence of): c. <i>Atherosclerosis -</i> Due to (or as a consequence of): <i>Thrombotic stroke syndrome</i>								Approximate Interval Between Onset and Death 5 yrs 8 yrs 8 yrs 8 yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive pulmonary disease</i> <i>Life long Venous and lymphatic insufficiency</i>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number H44037		29d. Date signed (Month, Day, Year) 01/04/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Bonita Krenpel-Bartler</i> 52 WATER ST THURMONT, MD 21782								
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42620

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY				2. Date of Death Month DECEMBER Day 29 Year 1999 11:20 P.M.				3. Time of Death			
	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death			
Funeral Director	5. Social Security Number 214-36-0904		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) Nov 19 1932		9. Birthplace (State or Foreign Country) Brunswick, MD			
	Usual Residence of Decedent				10a. State MD		10b. County Frederick		10c. City, Town or Location Brunswick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 1100 Peach Orchard Lane				10f. Zip Code 21716				10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Senior Analyst				16b. Kind of Business/Industry National Geographic Society				
17. Father's Name (First, Middle, Last) William Ernest Onley				18. Mother's Name (First, Middle, Maiden Surname) Lottie Ellen Hardy								
19a. Informant's Name/Relationship (Type, Print) Faye H. Williams, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Second Avenue, Brunswick, MD 21716								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fairview Cemetery				20c. Location - City or Town, State Frederick, MD		20d. Date 1/5/2000		
21. Signature of Funeral Service Licensee Barbara A. Williams, Owner				22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. RECURRENT ACUTE MYELOGENOUS LEUKEMIA 7 MONTHS Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 3 DAYS				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Kelly Dooley MD				29c. License number RES-000		29d. Date signed (Month, Day, Year) December 31, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelly Dooley, Tower 110, Doctors Lounge, Johns Hopkins, Baltimore, Maryland 21287												
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42621

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LARRY W. HAINES				2. Date of Death Month Day Year DECEMBER 27 1999		3. Time of Death 1853	
	4a. Facility Name (If not institution, give street and number) STROY GROVE BOUGHTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 216-58-6771		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		8. Date of Birth (Month, Day, Year) July 7 1954	
	9. Birthplace (State or Foreign Country) MD		10. Usual Residence of Decedent 10a. State MD		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 14251 Quince Orchard Rd.		10f. Zip Code 20878		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Delivery			
	17. Father's Name (First, Middle, Last) Delton Haines, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Barbara Hahn			
	19a. Informant's Name/Relationship (Type, Print) Wanda Haines/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14251 Quince Orchard Rd. Gaithersburg, MD 20878			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Cemetery		20c. Location - City or Town, State 12/31 Frederick, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hilton Funeral Home Box 86 Barnesville, MD 20838			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number 015236		29d. Date signed (Month, Day, Year) DECEMBER 27, 1999	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL MARGOLIS, M.D. 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852							
	31. Date filed (Month, Day, Year) DEC 30 1999				32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42622

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Henry J. Higgins				2. Date of Death Month December Day 22 , Year 1999		3. Time of Death 6:28 PM		
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 218-01-2867		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 03, 1916	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 9701 Medical Center Drive				10f. Zip Code 20850		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Representative			16b. Kind of Business/Industry Food Distribution Co.		
17. Father's Name (First, Middle, Last) Willard Higgins				18. Mother's Name (First, Middle, Maiden Surname) Mamie Moxley					
19a. Informant's Name/Relationship (Type, Print) Judith E. Baker - Attorney				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 931-B Russell Avenue, Gaithersburg, Maryland 20879					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date 12/27/99		20c. Location - City or Town, State Frederick, Maryland			
21. Signature of Funeral Service Licensee Olin L. Molesworth				22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Hypoxic encephalopathy Due to (or as a consequence of): b. Hypotension Due to (or as a consequence of): c. Myocardial infarction Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death Days Days Days	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Aortic stenosis, Mitral regurgitation								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Alan S. Chanales MD							
29c. License number 29453		29d. Date signed (Month, Day, Year) December 23, 1999							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALAN S. CHANALES 15445 SHADY GROVE RD ROCKVILLE, MD 20850									
31. Date filed (Month, Day, Year) DEC 28 1999		32. Registrar's Signature Benita B. Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42623

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Owens Harrison						2. Date of Death Month December Day 20 , Year 1999		3. Time of Death 7:16 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital						4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 578-20-3508		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) June 28, 1914		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Mt. Airy				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 14415 Shirley Bohn Road						10f. Zip Code 21771		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mathematician				16b. Kind of Business/Industry U.S. Government		
17. Father's Name (First, Middle, Last) Joseph Owens Harrison, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Bertha Kemp				
19a. Informant's Name/Relationship (Type, Print) Frances D. Harrison / Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14415 Shirley Bohn Road Mt. Airy, Maryland 21771				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Pine Grove Cemetery		Date Dec 23 1999		20c. Location - City or Town, State Mt. Airy, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Home, P.A. 8 E. Ridgeville Blvd., Mt. Airy, Maryland 21771						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Parkinson's Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death Days Months										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebrovascular Disease										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier M. Tolone MD				29c. License number MD 51616				29d. Date signed (Month, Day, Year) 12-21-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1475 Tawey Ave Suite 204 Frederick MD 21702										
31. Date filed (Month, Day, Year) DEC 22 1999 Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Mary Hartman		2. Date of Death Month December Day 17 , Year 1999		3. Time of Death 11:23 AM	
4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital			4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
5. Social Security Number 213-16-1082		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	8. Date of Birth (Month, Day, Year) Feb. 23, 1924	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent					
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Ijamsville	
10e. Street and Number 10046 Old National Pike		10f. Zip Code 21754		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Worker	
16b. Kind of Business/Industry Fred. Co. School Board		17. Father's Name (First, Middle, Last) Roger Delaine Breckenridge		18. Mother's Name (First, Middle, Maiden Surname) Bessie Elizabeth White	
19a. Informant's Name/Relationship (Type, Print) Elizabeth Powell (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6005 Harley Road, Middletown, Maryland 21769			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Location - City or Town, State Frederick, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only conditions on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. Respiratory Failure Due to (or as a consequence of):			Approximate Interval Between Onset and Death 24 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Sepsis Due to (or as a consequence of):			1 week
		c. Small Bowel Obstruction Due to (or as a consequence of):			1 week
		d. Lung Cancer			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number D41866		29d. Date signed (Month, Day, Year) December 18, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hudhud, MD 801 Bell House Avenue, D3 Frederick, MD 21701					
31. Date filed (Month, Day, Year) DEC 21 1999		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 12625

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Linwood Jenkins

2. Date of Death

December 3, 1999 1832

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

220-18-0066

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 29, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

109 Devonshire Road

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: WW2

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

M. P. Moller Organ

17. Father's Name (First, Middle, Last)

Charles Albert Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Viola Long

19a. Informant's Name/Relationship (Type, Print)

Anna M. Jenkins Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 Devonshire Road Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

1/4/00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Gerald N. Minnich

22. Name and Address of Facility

Gerald N. Minnich
Funeral Home

305 N. Potomac Street
Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

021457

29d. Date signed (Month, Day, Year)

1/1/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDUL WAHEED, MD - 12824 - OAKHILL AVE. HAGERSTOWN, MD 21742

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020
perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42626

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Johnson

2. Date of Death

December 21, 1999

3. Time of Death

1:30

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

167-24-5249

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 26, 1930

9. Birthplace (State or Foreign Country)

Abington, PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Tolchester / Chestertown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21247 Chesapeake Rd.

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12 years

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electronics Engineer

16b. Kind of Business/Industry

Wilkinson Electronics

17. Father's Name (First, Middle, Last)

Clarence W. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Wreatha Sprouse Johnson

19a. Informant's Name/Relationship (Type, Print)

Harriet Johnson / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21247 Chesapeake Rd. Chestertown, Md 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Pauls Cemetery

Date

12/28/99

20c. Location - City or Town, State

Chestertown

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home
130 Speer Rd. Chestertown, Md 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. hemoptysis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. lung masses

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0052745

29d. Date signed (Month, Day, Year)

December 21, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph P. Regan 22 S. Greene St. Baltimore, MD

State
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1999

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42627

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VINCENT JOHN JEPPI

2. Date of Death
Month Day Year

December 23, 1999

3. Time of Death

12:30 P.M.

4a. Facility Name (If not institution, give street and number)

Hart Heritage Home

4b. City, Town, or Location of Death

Street

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

212-01-4622

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Mar. 31, 1913

9. Birthplace (State or Foreign
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1804 Alpine Drive

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?1 ☐ Yes 2 ☒ NoIf Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Owner/Operator-Tavern Keeper

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Joseph (u/k) Jeppi

18. Mother's Name (First, Middle, Maiden Surname)

Rosa (u/k) Papa

19a. Informant's Name/Relationship (Type, Print)

Vincent J. Jeppi - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1804 Alpine Drive, Forest Hill, Maryland 21050

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

12/27/99

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

50 West Broadway, Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. ISCHEMIC HEART DISEASE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending
investigation6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40938

29d. Date signed (Month, Day, Year)

December 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD A. DE SANTIS, PH.D., M.D., P.C.
715 SOUTH SHAMROCK ROAD
BEL AIR, MD 21014-4457State
Registrar

31. Date filed (Month, Day, Year)

DEC 29 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE AMERICAN BANKING COMPANY
NEW YORK, N. Y.
JAN 10 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42628

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret James				2. Date of Death Month Day Year December 21, 1999		3. Time of Death 6:40 P.M.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-34-0227	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 26, 1910		9. Birthplace (State or Foreign Country) Pennsylvania
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 31 West Patrick Street				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker		16b. Kind of Business/Industry Welfare Dept.		
17. Father's Name (First, Middle, Last) Elmer Rohrer Sager				18. Mother's Name (First, Middle, Maiden Surname) Edith Harman				
19a. Informant's Name/Relationship (Type, Print) Martha J. Nichols, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2140 Nodleigh Terrace, Jarrettsville, Md. 21084				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery, Dec. 27, 1999		Data		20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee 		M00255		22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701				
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Congestive heart failure</u> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <u>2 years</u>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Pacemaker, dementia, osteoarthritis</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D35183		29d. Date signed (Month, Day, Year) 12/22/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Ali J. Apantaku 300 W 9th St Frederick MD</u>								
31. Date filed (Month, Day, Year) DEC 23 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42629

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Marion Kammerer				2. Date of Death Month 12 Day 30 Year 99		3. Time of Death 1900	
	4a. Facility Name (If not institution, give street and number) Univ. of Maryland Medical System				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 215-24-6949		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 9, 1928	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location Aberdeen	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 4411 Philadelphia Road		10f. Zip Code 21001		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1946 1948		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Animal Caretaker		16b. Kind of Business/Industry U.S. Government		17. Father's Name (First, Middle, Last) Walter Norman Kammerer		
18. Mother's Name (First, Middle, Maiden Surname) Cecelia Jeanette Weaver		19a. Informant's Name/Relationship (Type, Print) Janet Gail Kammerer/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Craightown Road, Port Deposit, MD 21904		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entomb.		
20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens		20c. Location - City or Town, State Bel Air, MD		21. Signature of Funeral Service Licensee Wally K. McComas		22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009		
23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sepsis Respiratory Failure		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 12/30/99		
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Paul G. Clark M.D.		29c. License number P11958		
29d. Date signed (Month, Day, Year) 12/30/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul G. Clark M.D. 225 Green St. Balt. MD.		31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature Benita B. Sparks		

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, AL

1/03/2000

Shawn Robertson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42630

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harry Ralph Kersey Jr.					2. Date of Death Month Day Year December 27, 1999		3. Time of Death 7:10 AM												
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital					4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick												
Funeral Director	5. Social Security Number 218-64-2942		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) Jan 21, 1957		9. Birthplace (State or Foreign Country) Frederick MD											
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State MD		10b. County Frederick		10c. City, Town or Location Brunswick			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												
	10e. Street and Number 412 East "E" Street				10f. Zip Code 21716			10g. Citizen of What Country? USA												
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White												
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Yardmaster			16b. Kind of Business/Industry Chessie Systems CSX Baltimore												
	17. Father's Name (First, Middle, Last) Harry Ralph Kersey, Sr.					18. Mother's Name (First, Middle, Maiden Summa) Susie Delores Powers														
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Melinda Kay Barnhouse, Sister					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 East "E" Street, Brunswick, MD 21716														
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens 12/30			Date 12/30		20c. Location - City or Town, State Frederick, MD											
	21. Signature of Funeral Service Licensee Barbara A. Williams, Owner					22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. obstructive pneumonia Due to (or as a consequence of): b. Unresectable non-small cell carcinoma of the lung Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 month																			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. H/o Head injury, tracheostomy, left pneumothorax Hypertension, Anemia, Hypophosphatemia, testosterone deficiency																			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									
	28a. Date of Injury (Month, Day, Year)					28b. Time of Injury M					28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					28d. Describe how injury occurred				
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier no, no					29c. License number D47169					29d. Date signed (Month, Day, Year) 12/29/99									
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chan-Hing Ma Ho, MD 610 Ninth Avenue Brunswick Maryland 21716																			
	31. Date filed (Month, Day, Year) DEC 30 1999					32. Registrar's Signature B. Sparks														

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42631

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter William King				2. Date of Death Month Day Year December 24 1999		3. Time of Death 9:15 A.M.	
	4a. Facility Name (If not Institution, give street and number) 8820 Dr. Perry Road				4b. City, Town, or Location of Death Dickerson		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 217-10-9176		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 3, 1908	
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland		10b. County Frederick		10c. City, Town or Location Dickerson	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 8820 Dr. Perry Road		10f. Zip Code 20842		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Store owner/operator		16b. Kind of Business/Industry Dry Cleaner				
17. Father's Name (First, Middle, Last) James Albert King				18. Mother's Name (First, Middle, Maiden Surname) Rosa May Droneburg				
19a. Informant's Name/Relationship (Type, Print) Helen Burdette				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Dr. Perry Road, Dickerson, Maryland 20842				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date Dec. 28 1999		20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Multiple CVA's</u>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D30020		29d. Date signed (Month, Day, Year) 12/28/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John A. Shutta M.D., 15 E Franklin St, PO Box 30, Walkersville, Md 21793								
31. Date filed (Month, Day, Year) DEC 30 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42632
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Daryl Kovacs				2. Date of Death Month Day Year December 21, 1999		3. Time of Death 2:15 AM		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 283-36-8060		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 21, 1941		
	9. Birthplace (State or Foreign Country) Ohio		10a. State WV		10b. County Berkeley		10c. City, Town or Location Falling Waters		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1602 North Road		10f. Zip Code 25419		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1967-11/2/72		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Vitro Labs					
17. Father's Name (First, Middle, Last) Michael Daryl Kovacs, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Paulina Jaros					
19a. Informant's Name/Relationship (Type, Print) Peggie Kovacs (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1602 North Road, Falling Waters, WV 25419					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory		Date 12/22/99		20c. Location - City or Town, State Smithsburg, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE MYELOMA, IgA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 5 YEARS	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number D31761		29d. Date signed (Month, Day, Year) 12/21/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M. O'CONNOR MD 501 W. SEVENTH ST., FREDERICK, MD 21701									
31. Date filed (Month, Day, Year) DEC 22 1999		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42633

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EMMA GERTRUDE LITTON

2. Date of Death

Month Day Year
DECEMBER 29, 1999

3. Time of Death

4:00 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

GARRETT MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

OAKLAND

4c. County of Death

GARRETT

5. Social Security Number

220-92-4735

6. Sex

☐ M ☒ F

7. Age (in yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
MAY 17, 1925

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

GARRETT

10c. City, Town or Location

OAKLAND

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7th. & ALDER STREETS

10f. Zip Code

21550

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

UNKNOWN

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

ROY C. SHIPLEY

18. Mother's Name (First, Middle, Maiden Surname)

ROXY EDNA O'NEAL

19a. Informant's Name/Relationship (Type, Print)

ALVIN LITTON / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ROUTE 2, BOX 108-E, KEYSER, WV 26726

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SUNSET MEMORIAL PARK

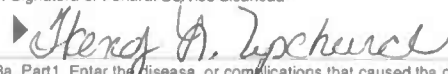
Date

1/4/00

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Influenza B
Due to (or as a consequence of):

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema, Chronic Schizophrenia, drug induced lupus

hypothyroid, chronic intermittent GI bleed

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D26650

29d. Date signed (Month, Day, Year)

12/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret A. Kaiser MD 13079 Garrett Highway Oakland MD 21550

31. Date filed (Month, Day, Year)

JAN 11 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42634

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stephen Langford				2. Date of Death Month December Day 28 Year 1999		3. Time of Death 12:05 AM		
	4a. Facility Name (If not institution, give street and number) 7103 Autumn Leaf Lane				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 228-68-8532		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 10, 1923		
	9. Birthplace (State or Foreign Country) England		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 7103 Autumn Leaf Lane		10f. Zip Code 21702		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman		16b. Kind of Business/Industry Manufacturing					
17. Father's Name (First, Middle, Last) Stephen Langford				18. Mother's Name (First, Middle, Maiden Surname) Frances Nellie Pearson					
19a. Informant's Name/Relationship (Type, Print) Mrs. Joan K. Langford, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7103 Autumn Leaf Lane, Frederick, Md. 21702					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory, Dec. 29, 1999		20c. Location - City or Town, State Smithsburg, Md.					
21. Signature of Funeral Service Licensee Richard E. [Signature] M00255		22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701							
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>extensive colon carcinoma</u> Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		Approximate Interval Between Onset and Death 2.5	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) _____		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred _____	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D1462C		29d. Date signed (Month, Day, Year) December 28, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. [Signature]		31. Date filed (Month, Day, Year) DEC 29 1999		32. Registrar's Signature [Signature]					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42635

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Lust				2. Date of Death Month Day Year December 27 1999				3. Time of Death 12:30 PM		
	4a. Facility Name (If not institution, give street and number) 43 East "C" Street				4b. City, Town, or Location of Death Brunswick				4c. County of Death Frederick		
Funeral Director	5. Social Security Number 219-34-5756		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) May 16 1936		9. Birthplace (State or Foreign Country) Weverton MD		
	Usual Residence of Decedent				10a. State MD				10b. County Frederick		10c. City, Town or Location Brunswick
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 43 East "C" Street				10f. Zip Code 21716		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife				16b. Kind of Business/Industry Homemaker			
17. Father's Name (First, Middle, Last) John Raymond Darr				18. Mother's Name (First, Middle, Maiden Surname) Abbey C. Longerbeam							
19a. Informant's Name/Relationship (Type, Print) Jack Lust, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 3, Box 170W10, Kearneysville, WV 25430							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Reformed Cemetery				Date 12/31/99		20c. Location - City or Town, State Knoxville, MD	
21. Signature of Funeral Service Licensee <i>Barbara A. Williams</i> Barbara A. Williams, Owner				22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Abdominal Carcinomatosis Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 9 m											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Ethamy Eskander MD</i>				29c. License number D 48184				29d. Date signed (Month, Day, Year) Dec 29, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ethamy Eskander, MD 501 W 7th street Frederick MD 21701											
31. Date filed (Month, Day, Year) DEC 30 1999				32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42637

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel Mae Leishear				2. Date of Death Month December Day 20 , Year 1999		3. Time of Death 10:00 P.M.	
	4a. Facility Name (If not institution, give street and number) Frederick Health Care Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-34-2473		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 1, 1914	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Damascus	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 12500 Prices Distillery Road		10f. Zip Code 20872		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home			
	17. Father's Name (First, Middle, Last) Covington Benjamin Zepp				18. Mother's Name (First, Middle, Maiden Surname) Anna Louise Lehman			
	19a. Informant's Name/Relationship (Type, Print) Chester M. Leishear - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20872 12500 Prices Distillery Road, Damascus, Maryland			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. View Cemetery		20c. Date 12/23/99		20d. Location - City or Town, State Damascus, Maryland	
	21. Signature of Funeral Service Licensee Olin L. Molesworth				22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral-vascular accident Dua to (or as a consequence of): b. arteriosclerotic cardiovascular disease Dua to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last c. Dua to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASPIRATION PNEUMONIA							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Ronald E. Miller M.D.				29c. License number D26499		29d. Date signed (Month, Day, Year) 12-21-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, M.D. 4 Culwell Drive, Mount Airy, Maryland 21771								
31. Date filed (Month, Day, Year) DEC 22 1999				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42638

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Lester Leroy MYERS, III

2. Date of Death

Month

Day

Year

Dec. 30,

1999

3. Time of Death

13:08 pm

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

214-48-4245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 27, 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11115 Glenside Avenue

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

machinist

16b. Kind of Business/Industry

truck

17. Father's Name (First, Middle, Last)

Lester Leroy Myers, Jr.

18. Mother's Name (First, Middle, Maiden Summe)

Doris Warner

19a. Informant's Name/Relationship (Type, Print)

Emma Jean Myers - wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11115 Glenside Ave., Hagerstown, Md. 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Haven Cemetery

Date

1-3-00

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott Munnich

22. Name and Address of Facility

MINNICH FUNERAL HOME

415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS, WITH DISSEMINATED INTRAVASCULAR COAGULATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. _____
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

ACUTE RESPIRATORY FAILURE

HEPATIC CIRRHOSIS, LAENNEC'S

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

NONE

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Barry M. Cohen, MD

29c. License number

D01040

29d. Date signed (Month, Day, Year)

12-31-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry M. Cohen, MD, 18206 CRESTWOOD DRIVE, HAGERSTOWN, MD, 21742

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

D. Spence

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Myers, Lester Leroy III
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42639

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

IRMA F. MILLER

2. Date of Death

Month Day Year
Dec. 27, 1999

3. Time of Death

1 PM

4a. Facility Name (If not institution, give street and number)

Heron Point # 501 Campus Ave.

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral
Director

5. Social Security Number

220 46 1703

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Sept 3, 1906

9. Birthplace (State or Foreign Country)

Nebraska

Usual Residence of Decedent

10a. State

Md.

10b. County

Kent

10c. City, Town or Location

Chestertown # 423 Pintail Court

10d. Inside City Limits

Yes ☐ No ☒ 2 ☐ No

10e. Street and Number

501 Campus Ave (423 Pintail Court

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

No

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4 Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

in own home

17. Father's Name (First, Middle, Last)

Frank J. Fisher

18. Mother's Name (First, Middle, Maiden Surname)

Agnes V. Slazeck

19a. Informant's Name/Relationship (Type, Print)

The deceased while still living

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

501 Campus Ave # 423 Pintail Court 21620 Chestertown, Md

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Saint Paul's Cemetery

Date

20c. Location - City or Town, State

near Chestertown, Md.

21. Signature of Funeral Service Licensee

J. Willis Wells

22. Name and Address of Facility

Willis Wells Funeral Service
211 Heron PointChestertown, Md.
21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

> 8 yrs.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

BREAST CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Helen A Noble MD

29c. License number

D41587

29d. Date signed (Month, Day, Year)

12/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Helen A Noble Chestertown, Md. 21620

31. Date filed (Month, Day, Year)

DEC 29 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42640

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katherine Bryarly Manor

2. Date of Death

Dec. 24, 1999

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

Reeders Memorial Home

4b. City, Town, or Location of Death

Boonsboro

4c. County of Death

Washington

Funeral
Director

5. Social Security Number

212-38-7587

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept 27 1910

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Brunswick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

520 West Potomac Street

10f. Zip Code

21716

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

School Teacher

16b. Kind of Business/Industry

Brunswick Elementary School

17. Father's Name (First, Middle, Last)

James Manor

18. Mother's Name (First, Middle, Maiden Surname)

Cora Naylor

19a. Informant's Name/Relationship (Type, Print)

Eleanor Lakin, Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

121 Lakin Avenue, Boonsboro, MD 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mark's Cemetery

Date

12/27/99

20c. Location - City or Town, State

Petersville, MD

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home
100 Petersville Road, Brunswick, MD 21716

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Aspiration

Due to (or as a consequence of):

Unknown

c.

Senile Dementia

Due to (or as a consequence of):

years.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 44996

29d. Date signed (Month, Day, Year)

Dec. 24, 1999.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Zafar Malik 20311 Lappans Rd. Boonsboro, Md 21713 / 301-432-8470

31. Date filed (Month, Day, Year)

DEC 27 1999

32. Registrar's Signature

Zafar Malik

State
Registrar

Name: Manor, Katherine Bryarly

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner


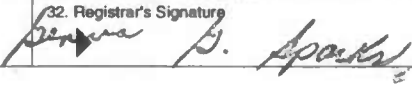
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42641

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PATRICIA, NEWTON				2. Date of Death Month December Day 27 Year 1999		3. Time of Death 15:36	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical System				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-52-2393		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) August 30, 1952	
	9. Birthplace (State or Foreign Country) Chestertown, Maryland		10a. State Maryland		10b. County Kent		10c. City, Town or Location Chestertown	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 101 Morgnac Road K202		10f. Zip Code 21620		
10g. Citizen of What Country? USA		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cosmotologist		16b. Kind of Business/Industry Beautician		
17. Father's Name (First, Middle, Last) Floyd Collins Price				18. Mother's Name (First, Middle, Maiden Surname) Grace Eva Carter				
19a. Informant's Name/Relationship (Type, Print) William Brian Gsell/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 831 High Street, Chestertown, Maryland 21620				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Still Pond Cemetery		20c. Date 12/31/99		20d. Location - City or Town, State Still Pond, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Renal Failure Due to (or as a consequence of): b. End stage Liver disease Due to (or as a consequence of): c. Alcoholic cirrhosis Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 				29c. License number P13363		29d. Date signed (Month, Day, Year) December 27, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Brown, M.D. 22 O. Greene St. Baltimore Md 21201								
31. Date filed (Month, Day, Year) DEC 29 1999				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42642

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Norman Nusbaum

2. Date of Death

Month Day Year
12-25-99 6:55 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

College View Center, 700 Toll House Ave Frederick

4b. City, Town, or Location of Death

4c. County of Death

Frederick

5. Social Security Number

219-12-0551

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 20, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7812 Spout Springs Road

10f. Zip Code

21702

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1943

If Yes, Give

Year or Dates: -1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working

life. DO NOT use retired)

Master Plumber

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Clotworthy Ruby Nusbaum

18. Mother's Name (First, Middle, Maiden Surname)

Stella May Warner

19a. Informant's Name/Relationship (Type, Print)

Susan A. Clark / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7197 Meadowbrooke Dr., Frederick, MD 21702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hagerstown Crematory

Date

12/27/99

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Paul P. B. Mackay

22. Name and Address of Facility

Stauffer Funeral Homes, P.A.

1621 Opossumtown Pike, Frederick, Maryland 21702

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Sepsis

Due to (or as a consequence of):

ONE week

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Pressure ulcer, diabetes one week

Due to (or as a consequence of):

c. Deep Vein Thrombosis, Alzheimers dementia,

Due to (or as a consequence of):

d. Hypertension, Seizure, Bipolar depression

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen Lee MD

29c. License number

D42641

29d. Date signed (Month, Day, Year)

12-25-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Lee MD 610 Solarex Ct. Frederick MD 21703

31. Date filed (Month, Day, Year)

DEC 30 1999

32. Registrar's Signature

B. Spaul

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
card.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42643

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wayne Nelson Ohler						2. Date of Death Month Day Year December 21 1999		3. Time of Death 0110 AM										
	4a. Facility Name (If not institution, give street and number) Montgomery Hospice Casey House						4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery										
Funeral Director	5. Social Security Number 214-32-4923		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) 11/27/34		9. Birthplace (State or Foreign Country) VA										
	Usual Residence of Decedent																		
10a. State MD		10b. County Montgomery		10c. City, Town or Location Germantown				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
10e. Street and Number 19359 Hottinger Circle				10f. Zip Code 20874		10g. Citizen of What Country? U.S.A.													
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1954 If Yes, Give Year or Dates: 1962		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White												
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supply Supervisor			16b. Kind of Business/Industry N.I.H.												
17. Father's Name (First, Middle, Last) Ed Ohler						18. Mother's Name (First, Middle, Maiden Summa) Alice Dubel													
19a. Informant's Name/Relationship (Type, Print) Sharon Norris/wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19359 Hottinger Circle, Germantown, MD 20874													
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gdns		20c. Location - City or Town, State Frederick, MD 21701		20d. Date 12/21/99											
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility J.N. Zambrun F.H. 6028 Sykesville Road, Eldersburg, MD 21784													
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Lung cancer metastatic</td> <td rowspan="4"> Approximate Interval Between Onset and Death 5 months </td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Lung cancer metastatic	Approximate Interval Between Onset and Death 5 months	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Lung cancer metastatic	Approximate Interval Between Onset and Death 5 months																
	b.	Due to (or as a consequence of):																	
	c.	Due to (or as a consequence of):																	
	d.	Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. coronary artery disease								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice																	
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier 						29c. License number D35996		29d. Date signed (Month, Day, Year) 12/21/99											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M. Burrell, M.D. 2101 Medical Park Dr. #210 Silver Spring, MD 20902																			
31. Date filed (Month, Day, Year) DEC 22 1999		32. Registrar's Signature 																	

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42644

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

HAROLD MERRELL PARKER

2. Date of Death

Month Day Year

12-23-1999 06:37AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

ER FAULTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

5. Social Security Number

236-52-3325

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
May 25, 1936

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1105 Andreas Drive

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Sand & Gravel

Manufacturer

17. Father's Name (First, Middle, Last)

Cloyd Martin Parker

18. Mother's Name (First, Middle, Maiden Surname)

Helen Kathleen Cunningham

19a. Informant's Name/Relationship (Type, Print)

Ruby Lane Parker/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1105 Andreas Drive, Bel Air, MD 21015

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bel Air Memorial Gardens 12-27-99 Bel Air, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of):

DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia

HYPERTENSION

PARKINSONS

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☐ Medical Examiner☒ Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DEC 23 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRABER MD 218 FALLMONT AVE BELAIR MD 21014

31. Date filed (Month, Day, Year)

DEC 27 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42645

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MAURICE SAMUEL PRYOR				2. Date of Death Month Day Year Dec 31 1999		3. Time of Death 4:15 pm					
	4a. Facility Name (If not institution, give street and number) Fahrney-Keedy Nursing Home				4b. City, Town, or Location of Death Boonsboro		4c. County of Death Washington					
Funeral Director	5. Social Security Number 214-36-0116	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 18, 1915	9. Birthplace (State or Foreign Country) Maryland					
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Smithsburg			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 13502 Loy Wolfe Road			10f. Zip Code 21783		10g. Citizen of What Country? USA						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Dairy Farm							
	17. Father's Name (First, Middle, Last) Theophilus Pryor			18. Mother's Name (First, Middle, Maiden Surname) Rosa Kline								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Richard Pryor/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13500 Loy Wolfe Road, Smithsburg, MD 21783								
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Grossnickle Brethren Cemtl-4-2000		20c. Location - City or Town, State Myersville, Maryland							
	21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773								
	23a. Part I. Enter the disease, or combination that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Congestive Cardiomypopathy</i></td> <td rowspan="4">Approximate Interval Between Onset and Death <i>4 weeks</i></td> </tr> <tr> <td>b. <i>Systemic Amyloidosis</i></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	a. <i>Congestive Cardiomypopathy</i>	Approximate Interval Between Onset and Death <i>4 weeks</i>	b. <i>Systemic Amyloidosis</i>	c.
Immediate Cause (Final disease or condition resulting in death)	a. <i>Congestive Cardiomypopathy</i>	Approximate Interval Between Onset and Death <i>4 weeks</i>										
	b. <i>Systemic Amyloidosis</i>											
	c.											
	d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Peripheral neuropathy</i> <i>Hypertension</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred										
28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D44996		29d. Date signed (Month, Day, Year) Jan 1, 2000						
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Zafar Malik MD 20311 Lappans Rd Boonsboro, MD 21713												
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature <i>[Signature]</i>										

Sept 1900

Sept 1900

Sept 1900

For sale by the Government
Sept 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42646

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Cecil Perry

2. Date of Death

December 30 1999

3. Time of Death

06:01 AM.

4a. Facility Name (If not institution, give street and number)

213 Linden Boulevard

4b. City, Town, or Location of Death

Middletown

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

213-32-8280

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Dec. 14, 1932

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD.

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

213 Linden Blvd.

10f. Zip Code

21769

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates: 1952-1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

air traffic controller

16b. Kind of Business/Industry

federal gov't.

17. Father's Name (First, Middle, Last)

Glenn Perry

18. Mother's Name (First, Middle, Maiden Surname)

Irene Taylor

19a. Informant's Name/Relationship (Type, Print)

Margaret M. Perry (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213 Linden Blvd., Middletown, MD. 21769

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

1/1/00

20c. Location - City or Town, State

Smithsburg, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home

31 E. Main St., Middletown, MD. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Contact Shotgun Wound of HEAD

Brief

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☒ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

12/30/99

28b. Time of Injury (and)

0552 A M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Self-inflicted shotgun wound

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

213 LINDEN BLVD

Middletown, MD

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

December 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. TRUS, M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2028.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42647

Amended item#26per doctor,1/04/2000 Certificate of Death FCHD,KS Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedant's Name (First, Middle, Last) JUNE LENORE PUTMAN		2. Date of Death Month Day Year December 30, 1999		3. Time of Death 1628
4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital		4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick
5. Social Security Number 212-88-0332	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	8. Date of Birth (Month, Day, Year) June 12, 1922	9. Birthplace (State or Foreign Country) Pennsylvania
Usual Residence of Decedent				
10a. State Maryland	10b. County Frederick	10c. City, Town or Location Knoxville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
10e. Street and Number 3857 South Mountain Road		10f. Zip Code 21758		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Clarence Snider		18. Mother's Name (First, Middle, Maiden Surname) Bessie Neal		
19a. Informant's Name/Relationship (Type, Print) Alton R. Putman (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3857 South Mountain Road, Knoxville, Maryland 21758		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Location - City or Town, State Frederick, Maryland
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cerebral Artery Disease</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 yrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension</u>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 11/30/99		28b. Time of Injury M
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and Title of Certifier 		29c. License number D-13971		29d. Date signed (Month, Day, Year) 1/3/00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 W. 9th Street, Frederick, MD 21701 Robert L. Kaufman, MD				
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature 		

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42648

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Elbert S. Padgett		2. Date of Death Month December Day 27 Year 1999		3. Time of Death 2:00 A.M.	
4a. Facility Name (If not institution, give street and number) 11 Rosewood Court Unit 105			4b. City, Town, or Location of Death Woodsboro		4c. County of Death Frederick
5. Social Security Number 351-09-1695	8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 24, 1916
9. Birthplace (State or Foreign Country) Missouri					
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Woodsboro	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 11 Rosewood Court, Unit 105			
10f. Zip Code 21798		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry New York Public Works Dept.	
17. Father's Name (First, Middle, Last) Harry R. Padgett			18. Mother's Name (First, Middle, Maiden Surname) Edna Wise		
19a. Informant's Name/Relationship (Type, Print) Katharine Powell/step-daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2826 Wildwood Cr., Walkersville, MD 21793		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cem. of the Holy Rood		20c. Location - City or Town, State 1/3/00 Westbury, New York	
21. Signature of Funeral Service Licensee Guadalupe Kren		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Md. 21702			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Congestive Heart Failure Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Approximate Interval Between Onset and Death weeks years					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Thromboses					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier William H. Convey, M.D.		29c. License number D20395		29d. Date signed (Month, Day, Year) 12/27/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. CONVEY, M.D., 195 THOMAS JOHNSON DR., FREDERICK, MD 21702					
31. Date filed (Month, Day, Year) DEC 30 1999		32. Registrar's Signature Benita B. Spaw.			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42649

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GEORGE IRVIN PEACH

2. Date of Death

Month Day Year
12 24 99

3. Time of Death

7:15 PM

4e. Facility Name (If not Institution, give street and number)

FREDERICK HEALTH CARE CENTER

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

215-20-7841

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
OCT. 21, 1923

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

FREDERICK

10c. City, Town or Location

FREDERICK

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

102 WEST THIRD ST.

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
N/A

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ARTHUR PEACH

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH BOWIE

19e. Informant's Name/Relationship (Type, Print)

PAUL PEACH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3113 WILDFLOWER CREEK DR.
MARTINSBURG, W.VA. 25401

20e. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREM.

Date

DEC. 31, 99 BALT. MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gary L. Rollins

22. Name and Address of Facility

GARY L. ROLLINS FUNERAL HOME
110 WEST SOUTH ST FRED. MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Aspiration Pneumonia

Due to (or as a consequence of):

b.

Dementia

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

Decubitus Ulcer

Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William H. Johnson MD

29c. License number

D47556

29d. Date signed (Month, Day, Year)

12/24/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WILLIAM H. JOHNSON MD 172 THOMAS JOHNSON DRIVE, FREDERICK MD 21702

31. Date filed (Month, Day, Year)

DEC 29 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42650**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Darrell Putman

2. Date of Death
Month Day Year

December 23 1999

3. Time of Death

3:30 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Systems

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

216-54-7802

6. Sex

1 ☒ M ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Sep 1, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Lisbon

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

16061 A.E. Mullinux Road

10f. Zip Code

21765

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.
Armed Forces?

☒ Yes ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Equestrian Services

16b. Kind of Business/Industry

Husbandry (Horses)

17. Father's Name (First, Middle, Last)

Ralph Asper Putman

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Evelyn Free

19a. Informant's Name/Relationship (Type, Print)

Shaylene Murphy Putman/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16061 A.E. Mullinux Rd, Lisbon, Maryland 21765

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rocky Springs Cemetery Dec 28, 1999 Frederick, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Keeney & Basford P.A. Funeral Home
MO0706

22. Name and Address of Facility

106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Non Hodgkins Lymphoma

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy
performed?

☐ Yes ☒ No

24b. Were autopsy findings
available prior to
completion of cause
of death?

☐ Yes ☐ No

25. Was case referred to medical
examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury
(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

29a. Certifier
(Check only
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Asha Murthy M.D 10448

29c. License number

AU4176435

29d. Date signed (Month, Day, Year)

December 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Asha Murthy MD, University of Maryland 22 South Greene Street, Baltimore

31. Date filed (Month, Day, Year)

DEC 28 1999

32. Registrar's Signature

Beverly B. Asper

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

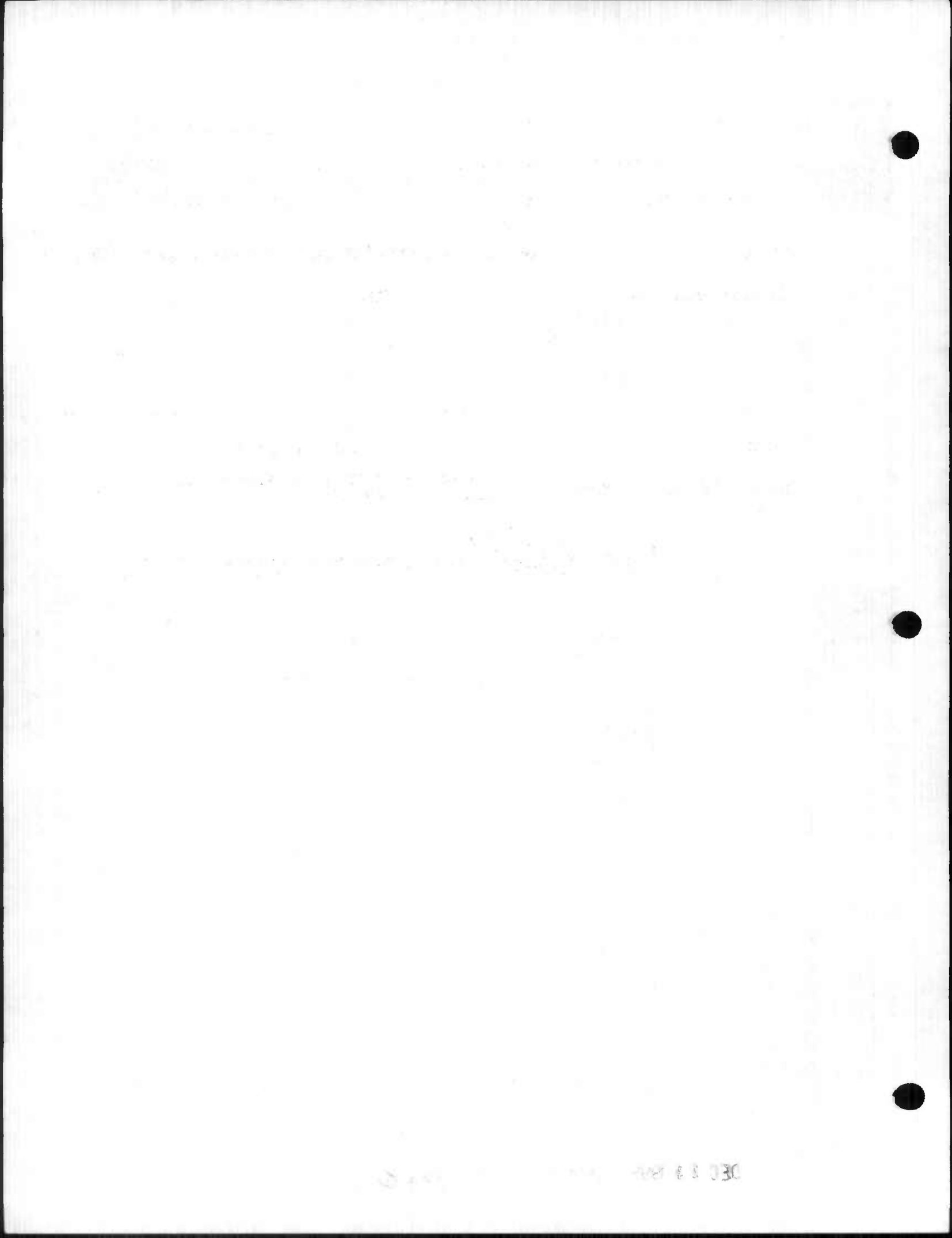
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

99 42651

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42652

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Herman Andrew Rasnake						2. Date of Death Month Day Year December 28 1999			3. Time of Death 6:20 AM			
	4a. Facility Name (If not institution, give street and number) Citizens Nursing Home						4b. City, Town, or Location of Death Havre de Grace			4c. County of Death Harford			
Funeral Director	5. Social Security Number 213-16-1128		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) June 1, 1915	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent												
10a. State MD		10b. County Harford		10c. City, Town or Location Havre de Grace						10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 100 Revolution Street Apt. 604				10f. Zip Code 21078				10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck driver				16b. Kind of Business/Industry Construction					
17. Father's Name (First, Middle, Last) Richard Rasnake						18. Mother's Name (First, Middle, Maiden Surname) Virginia Ball							
19a. Informant's Name/Relationship (Type, Print) Cliff Rasnake (Brother)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2370 Happy Lane Jacksonville, Florida 32218							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Bel Air Memorial Gardens				Date 12/30/99		20c. Location - City or Town, State Bel Air, Maryland			
21. Signature of Funeral Service Licensee Kenneth B. Cargo						22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Prostate with metastasis Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												Approximate Interval Between Onset and Death > 1 yr.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier K. W. ... MD.						29c. License number D 32609			29d. Date signed (Month, Day, Year) 12/28/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth B. Cargo MD 703 Revolution St - Havre de Grace MD 21078													
31. Date filed (Month, Day, Year) DEC 29 1999				32. Registrar's Signature B. South									

Follow Date
our Stamp Book while I was stamping
date
Junda H. D. Vitaliano

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42653

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROSE ELLEN RICHARDSON				2. Date of Death Month Day Year December 31, 1999		3. Time of Death 3:45 A.M.	
	4a. Facility Name (If not Institution, give street and number) 207 Kennard Avenue				4b. City, Town, or Location of Death Edgewood		4c. County of Death Harford	
Funeral Director	5. Social Security Number 215-44-1191		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 15, 1944	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Harford		10c. City, Town or Location Edgewood	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 207 Kennard Avenue		10f. Zip Code 21040		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Public Education				
17. Father's Name (First, Middle, Last) Emory William Goodrich				18. Mother's Name (First, Middle, Maiden Surname) Rose Elizabeth Leight				
19a. Informant's Name/Relationship (Type, Print) John S. Richardson - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Kennard Ave., Edgewood, Maryland 21040				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Grdns.		Date 1/3/2000		20c. Location - City or Town, State Aldino, Maryland		
21. Signature of Funeral Services Licensee 				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Uterine Sarcoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 2 yrs.				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D41490		29d. Date signed (Month, Day, Year) 12/31/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael McCollum MD 9105 Franklin Square Dr. Balt. Md 21237								
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42654

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD WILLIAM ROELKE, JR				2. Date of Death Month Day Year DECEMBER 29, 1999		3. Time of Death 6:20 AM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick County	
Funeral Director	5. Social Security Number 214-42-0836		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 14, 1943	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick County		10c. City, Town or Location Frederick	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3 East Ninth Street		10f. Zip Code 21701		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+) Collega		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) custodian		16b. Kind of Business/Industry law enforcement				
17. Father's Name (First, Middle, Last) Harold William Roelke, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Airy V. Burck				
19a. Informant's Name/Relationship (Type, Print) Airy V. Keeney, mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 East Ninth Street, Frederick, MD 21701				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State 12/31/99 Frederick, Maryland				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Keeney and Basford Funeral Home MO0999 106 East Church Street, Frederick, MD 21701						
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE GASTROINTESTINAL HEMORRHAGE Due to (or as a consequence of): b. HEPATIC METASTASES Due to (or as a consequence of): c. NON-SMALL CELL LUNG CANCER Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death 2 DAYS 2 MONTHS 2 MONTHS				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERCALCEMIA OF MALIGNANCY						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 		29c. License number D 31761		29d. Date signed (Month, Day, Year) 12/29/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M. O'CONNOR, MD 501 W. SEVENTH ST. FREDERICK, MD 21701								
31. Date filed (Month, Day, Year) DEC 30 1999		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42655

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Willard Dempsey Ruffner</i>				2. Date of Death Month Day Year <i>December 28 1999</i>		3. Time of Death <i>12:22AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death	
Funeral Director	5. Social Security Number <i>219-07-8994</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>80</i> Yrs.	<input type="checkbox"/> Under 1 Year Months Days	<input type="checkbox"/> Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>July 16, 1919</i>	9. Birthplace (State or Foreign Country) <i>West Virginia</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Frederick</i>		10c. City, Town or Location <i>Frederick</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>813 Motter Avenue</i>				10f. Zip Code <i>21701</i>		10g. Citizen of What Country? <i>United States</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Painting Contractor</i>		16b. Kind of Business/Industry <i>Home Improvement</i>		
17. Father's Name (First, Middle, Last) <i>Joshua Phillip Ruffner</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Eva Elizabeth Collins</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Nova V. Ruffner / Wife</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>813 Motter Avenue Frederick, Maryland 21701</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Olivet Cemetery</i>		Date <i>Dec 31 1999</i>		20c. Location - City or Town, State <i>Frederick, Maryland</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Asystole</i> Due to (or as a consequence of): b. <i>Hypoxia</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Prostate cancer</i> <i>Lung Cancer</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>						
29c. License number <i>P12456</i>		29d. Date signed (Month, Day, Year) <i>December 28, 1999</i>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Lisa Nipkow University of Maryland 22 South Greene Street Baltimore, MD</i>								
31. Date filed (Month, Day, Year) <i>DEC 30 1999</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42656

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN THOMAS ROUTZAHN SR.				2. Date of Death Month Day Year DECEMBER 25, 1999		3. Time of Death 6:15 AM													
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick													
Funeral Director	5. Social Security Number 212-10-8228	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 30, 1906		9. Birthplace (State or Foreign Country) MD.												
	Usual Residence of Decedent																			
10a. State MD.		10b. County Frederick		10c. City, Town or Location Middletown		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No														
10e. Street and Number 409 E. Main St.				10f. Zip Code 21769		10g. Citizen of What Country? U.S.A.														
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) president/officer		16b. Kind of Business/Industry insurance co.														
17. Father's Name (First, Middle, Last) John Lewis Routzahn				18. Mother's Name (First, Middle, Maiden Sumame) Lucie Thomas																
19a. Informant's Name/Relationship (Type, Print) J. Thomas Routzahn Jr. (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 E. Main St., Middletown, MD. 21769																
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lutheran Cemetery		Data 12/29		20c. Location - City or Town, State Middletown, MD.														
21. Signature of Funeral Service Licensee <i>Donald B. Thompson</i>				22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD. 21769																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. Sepsis</td> <td>Due to (or as a consequence of):</td> <td>3 days</td> </tr> <tr> <td>b. Pneumonia</td> <td>Due to (or as a consequence of):</td> <td>3 days</td> </tr> <tr> <td>c. Colitis</td> <td>Due to (or as a consequence of):</td> <td>several months</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsis	Due to (or as a consequence of):	3 days	b. Pneumonia	Due to (or as a consequence of):	3 days	c. Colitis	Due to (or as a consequence of):	several months	d.	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sepsis	Due to (or as a consequence of):	3 days																	
	b. Pneumonia	Due to (or as a consequence of):	3 days																	
	c. Colitis	Due to (or as a consequence of):	several months																	
	d.	Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. Anemia, neutropenia, renal failure						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and Title of certifier <i>Green, MD</i>				29c. License number D0054705		29d. Date signed (Month, Day, Year) 12/25/99														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine Buki 300 West 9th Street Frederick MD 21701																				
31. Date filed (Month, Day, Year) DEC 29 1999				32. Registrar's Signature <i>B. Spaul</i>																

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42657

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELMER CLAY RICE

2. Date of Death

December 25, 1999

3. Time of Death

10:30 PM

4a. Facility Name (If not institution, give street and number)

1 Victor Drive

4b. City, Town, or Location of Death

Thurmont

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

220-16-0703

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 17, 1923 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Thurmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1 Victor Drive

10f. Zip Code

21788

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Moores Business Comm.

17. Father's Name (First, Middle, Last)

Lewis S. Rice

18. Mother's Name (First, Middle, Maiden Surname)

Annie E. Fultz

19a. Informant's Name/Relationship (Type, Print)

Joan E. Andersen Rice (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Victor Drive, Thurmont, Maryland 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lewistown Cemetery

Date

12/29/99

20c. Location - City or Town, State

Lewistown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

29c. License number

D16428

29d. Date signed (Month, Day, Year)

12/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper E. Cline III, MD 300 West Ninth Street, Frederick, Maryland 21701

State
Registrar

31. Date filed (Month, Day, Year)

DEC 28 1999

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

99 42658

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Similar, Helen

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42659

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louise Shipley Sutter				2. Date of Death Month Day Year Dec. 29, 1999				3. Time of Death 2:00 P. M.	
	4a. Facility Name (If not institution, give street and number) 8507 Mapleville Road Apt. 1103				4b. City, Town, or Location of Death Boonsboro				4c. County of Death Washington	
Funeral Director	5. Social Security Number 218-30-9503		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) June 22, 1905		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Washington		10c. City, Town or Location Boonsboro				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 8507 Mapleville Road Apt. 1103				10f. Zip Code 21713		10g. Citizen of What Country? USA				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self Employed				16b. Kind of Business/Industry Beauty Shop		
17. Father's Name (First, Middle, Last) John Henry Sutter				18. Mother's Name (First, Middle, Maiden Surname) Oda Louise Shipley						
19a. Informant's Name/Relationship (Type, Print) Karen D. Kiley Trust Officer				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 59 W. Washington Street Hagerstown, Maryland 21740						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rose Hill Cemetery		20c. Date 1/3/00		20d. Location - City or Town, State Hagerstown, Maryland				
21. Signature of Funeral Service Licensee <i>Gerald N. Minnich</i>				22. Name and Address of Facility Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. arteriosclerotic coronary artery disease 15 years Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Robert Brull MD Personal Physician				29c. License number D04359				29d. Date signed (Month, Day, Year) 01/11/2000		
30. Name and address of person who completed cause of death (Item 29e) (Type, Print) Robert Brull M.D. 1459 Potomac Ave. Hagerstown, MD 21742										
31. Date filed (Month, Day, Year) JAN 10 2000		32. Registrar's Signature <i>Benjamin S. Sparks</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42660

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Palmer Rodney Schlegel

2. Date of Death

December 20, 1999

3. Time of Death

9:00 pm

4a. Facility Name (If not institution, give street and number)

708 Clayton Street

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

5. Social Security Number

186-28-5142

6. Sex

M 2 F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Apr. 24, 1931

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

708 Clayton Street

10f. Zip Code

21001

10g. Citizen of What Country?

21001

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 1953-5513. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12College (1-4 or 5+)
5+16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Mathematician

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Allen Schlegel

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Faye Troutman

19a. Informant's Name/Relationship (Type, Print)

Mrs. Marian A. Schlegel (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

708 Clayton Street, Aberdeen, Maryland 21001

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

R. A. Ferris & Co., Inc. 12/22/99 West Chester, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kenneth B. Cargo

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-339923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

Metastatic Bladder Cancer

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide 4 Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature], MD

29c. License number

D33759

29d. Date signed (Month, Day, Year)

12/22/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. Greene St., Baltimore, MD 21201

State
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1999

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42661

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELEANOR COCHRAN SIX				2. Date of Death Month Day Year Dec. 27, 1999		3. Time of Death 11:40 AM	
	4a. Facility Name (If not institution, give street and number) 2019 Pleasantville Road				4b. City, Town, or Location of Death Fallston		4c. County of Death Harford	
Funeral Director	5. Social Security Number 218-40-8583		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/7/1914	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD.		10b. County Harford		10c. City, Town or Location Fallston			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2019 Pleasantville Road				10f. Zip Code 21047		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Anthony Cochran				18. Mother's Name (First, Middle, Maiden Surname) Catherine Stephens				
19a. Intendant's Name/Relationship (Type, Print) Robert M. Six /Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 a,b,c,e,f				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Cemetery		Date 12/30		20c. Location - City or Town, State Hydes, Maryland		
21. Signature of Funeral Service Licensee M. Gladden Kurtz III				22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Stroke Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 month
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Heart Disease Renal Failure						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Willard P. Amoss						
29c. License number D0004354		29d. Date signed (Month, Day, Year) December 27, 1999						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willard P. Amoss 2303 Bel Air Road Fallston, Md. 21047								
31. Printed (Month, Day, Year) DEC 29 1999		32. Registrar's Signature [Signature]						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

1960 10 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42662**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Harold Delano Stacey

2. Date of Death
Month Day Year
December 26, 1999

3. Time of Death

5:45 P.M.

4a. Facility Name (If not institution, give street and number)

1112 North Stepney Road

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

Funeral
Director

5. Social Security Number

223-42-2815

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 2, 1936

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1112 North Stepney Road

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Building Maintenance Supervisor Shoe Manufacturer

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Will Farley Stacey

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Belle Harman

19a. Informant's Name/Relationship (Type, Print)

Harold D. Stacey, Jr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1917 Churchville Rd., Bel Air, MD 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Harford Memorial Gardens 12-30-99 Aldino, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician:2 ☒ Medical Examiner:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DME

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DEC 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YPRAGHU M.D 218 RULFORD AVE BELAIR MD 21014

31. Date filed (Month, Day, Year)

DEC 30 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, TL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42663
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clifford Andrew Smith

2. Date of Death
Month Day Year

December 27, 1999

3. Time of Death

9:47 PM

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital of Maryland, Inc.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

526-54-3204

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

April 10, 1933

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2407 Sycamore Lane

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1951 - 1971

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

18e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Military

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

George (u/k) Smith

18. Mother's Name (First, Middle, Maiden Surname)

Laura (u/k) McCormick

19a. Informant's Name/Relationship (Type, Print)

Barbara O'Neil - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

706 Lelia Ct., Bel Air, Maryland 21014

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

12-30-99

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Rd., Abingdon, Maryland 21009

23a. Part I. Enter the illness, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

VENTRICULAR ARRHYTHMIA

Approximate Interval Between Onset and Death

30 min

Due to (or as a consequence of):

CORONARY ARTERY DIS

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BRAIN TUMOR

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08344

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Luis E. Rivera, 5714 Harford Road, Baltimore, Maryland 21214

31. Date filed (Month, Day, Year)

DEC 30 1999

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42664

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Melvin Skelley

2. Date of Death
Month Day Year
DECEMBER 30 19993. Time of Death
8:05 AM

4a. Facility Name (If not institution, give street and number)

Brant Road (P.O. Box 5281)

4b. City, Town, or Location of Death

Cresaptown

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

216-09-3440

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sep 23, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cresaptown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Brant Road (P.O. Box 5281)

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Heavy Machine Operator

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John Skelley

18. Mother's Name (First, Middle, Maiden Surname)

Lottie (Chilcott)

19a. Informant's Name/Relationship (Type, Print)

Bonnie L. Horchler

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1101 Brookside Drive; Whitehouse, TX 75791

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Ambrose Cemetery

Date

1/03/

20c. Location - City or Town, State

Cresaptown, MD

21. Signature of Funeral Service Licensee

Nicholas J. Scarpelli

22. Name and Address of Facility

Scarpelli Funeral Home P.A.
Cumberland, Maryland 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gary Wagoner M.D.

29c. License number

D22181

29d. Date signed (Month, Day, Year)

December 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Wagoner M.D. Bishop Walsh Drive Cumberland MD 21502

31. Date filed (Month, Day, Year)

JAN 07 2000

32. Registrar's Signature

Benjamin S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten signature or initials.

0005 5 0 HAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42665
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND LESTER STONE

2. Date of Death

Month Day Year
December 31, 1999

3. Time of Death

1930

4a. Facility Name (If not institution, give street and number)

Sunrise Retirement Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

214-10-3431

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Oct. 23, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

990 Waterford Drive

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married

☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Counterman & Salesman

16b. Kind of Business/Industry

Automotive Parts Store

17. Father's Name (First, Middle, Last)

Harry G. Stone

18. Mother's Name (First, Middle, Maiden Surname)

Carrie E. Brandenburg

19a. Informant's Name/Relationship (Type, Print)

Linda R. Stone (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6920 Sundays Lane, Frederick, Maryland 21702

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery

Date

1/4/2000

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.

1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Carcinoma of Lung*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

[Signature]

29c. License number

D-13971

29d. Date signed (Month, Day, Year)

1/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 W. 9th Street, Fred. MD 21701

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42666

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emma Mae Simpson				2. Date of Death Month Day Year December 31, 1999				3. Time of Death 7:09 PM		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick		
Funeral Director	5. Social Security Number 214-28-5692		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 15, 1933		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 21 West All Saints Street				10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) George Washington Cleveland Shane					18. Mother's Name (First, Middle, Maiden Surname) Rosa Anna Mae Haines					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Stanley R. Shane, son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 West All Saints St., Frederick, Md. 21701						
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Smithsburg Crematory, Jan. 3, 2000				20c. Location - City or Town, State Smithsburg, Maryland		
	21. Signature of Funeral Service Licensee Richard E. Hargis MO0255				22. Name and Address of Facility Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <u>CARDIAC ARREST</u> Due to (or as a consequence of): b. <u>ATHEROSCLEROSIS</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										minutes yrs.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atherosclerosis.</u> <u>Peripheral Vascular disease</u> <u>Encephalo malacia.</u> <u>Seizures</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Naz A Hussain MD				29c. License number D46861				29d. Date signed (Month, Day, Year) 1/3/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAZ A HUSSAIN MD 195 T-J Drive Frederick MD 21702											
State Registrar		31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42667

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel David Snook				2. Date of Death Month Day Year December 29, 1999		3. Time of Death 9:18 P.M.		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 217-32-5744		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 15, 1923		
	9. Birthplace (State or Foreign Country) Maryland								
Usual Residence of Decedent									
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 6134 Mountaindale Road				10f. Zip Code 21788		10g. Citizen of What Country? United States			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Store proprietor			16b. Kind of Business/Industry Feed supply, hardware		
17. Father's Name (First, Middle, Last) Daniel Webster Snook				18. Mother's Name (First, Middle, Maiden Surname) Mary Margaret Fawcett					
19a. Informant's Name/Relationship (Type, Print) Clara Elizabeth Snook/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6134 Mountaindale Rd./ Thurmont, Maryland 21788					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Mem. Gardens		Date 1-3-2000		20c. Location - City or Town, State Frederick, Maryland		
21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Aortic Stenosis</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <i>5 years</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, history of colon cancer with colonomy</i>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Ali J. Afrakteh</i>		29c. License number D35183		29d. Date signed (Month, Day, Year) 1/3/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Ali J. Afrakteh 300 W 9th St Frederick MD</i>									
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42668

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Sylvester Snowden				2. Date of Death Month Day Year December 26, 1999				3. Time of Death 2:17 P.M.	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 217-30-6451		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 10, 1937		9. Birthplace (State or Foreign Country) Maryland	
	10a. State Maryland				10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 309 W. South Street		10f. Zip Code 21701		10g. Citizen of What Country? United States						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1955-59		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) owner/operator				16b. Kind of Business/Industry moving company		
17. Father's Name (First, Middle, Last) Arthur Snowden				18. Mother's Name (First, Middle, Maiden Surname) Geneva Bowie						
19a. Informant's Name/Relationship (Type, Print) Josephine Snowden / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 W. South St., Frederick, MD 21701						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fairview Cemetery		20c. Date 12/30/99		20d. Location - City or Town, State Frederick, Maryland				
21. Signature of Funeral Service Licensee ► Jacqueline Kreh				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) s. Metastatic Lung Cancer Due to (or as a consequence of):		Approximate Interval Between Onset and Death 10 years								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic disfigurement Pneumonia				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier ► William O. Miller		29c. License number D14373		29d. Date signed (Month, Day, Year) 12/27/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William O. Miller, MD 809 Tail House Dr Frederick, MD										
31. Date filed (Month, Day, Year) DEC 30 1999		32. Registrar's Signature B. Spaulding								

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42669

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George W. Schaeffer, Jr.				2. Date of Death Month Day Year December 25, 1999		3. Time of Death 9:40 AM										
	4a. Facility Name (If not institution, give street and number) Homewood Retirement Center				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick										
Funeral Director	5. Social Security Number 212-20-1374	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	8. Date of Birth (Month, Day, Year) Oct. 24, 1922	9. Birthplace (State or Foreign Country) Maryland												
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
	10e. Street and Number 6853 Buckthorn Court			10f. Zip Code 21703		10g. Citizen of What Country? U.S.A.											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer		16b. Kind of Business/Industry Farming												
	17. Father's Name (First, Middle, Last) George W. Schaeffer, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Alice L. Valentine												
	19a. Informant's Name/Relationship (Type, Print) Betty Lou Chadwell - Daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17650 Hardy Road, Mount Airy, Maryland 21771													
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date 12/28/99		20c. Location - City or Town, State Frederick, Maryland										
	21. Signature of Funeral Service Licensee Robert L. Williams		22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td rowspan="4"> { </td> <td>a. <u>Aspiration pneumonia</u> Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <u>2 Days</u></td> </tr> <tr> <td>b. <u>Cerebrovascular stroke</u> Due to (or as a consequence of):</td> <td><u>10 days</u></td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. <u>Aspiration pneumonia</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>2 Days</u>	b. <u>Cerebrovascular stroke</u> Due to (or as a consequence of):	<u>10 days</u>	c. _____ Due to (or as a consequence of):		d. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. <u>Aspiration pneumonia</u> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <u>2 Days</u>														
		b. <u>Cerebrovascular stroke</u> Due to (or as a consequence of):	<u>10 days</u>														
		c. _____ Due to (or as a consequence of):															
		d. _____ Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u> <u>Myelodysplasia</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																	
29b. Signature and title of certifier <u>[Signature]</u> MD				29c. License number D51643		29d. Date signed (Month, Day, Year) 12/27/99											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Hiren N. Shah 170 Thomas Johnson Dr., Suite 100 Frederick, MD 21702																	
31. Date filed (Month, Day, Year) DEC 28 1999		32. Registrar's Signature <u>[Signature]</u>															

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42670

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Smith				2. Date of Death December 22, 1999				3. Time of Death 7:20 pm	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-26-0090		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) March 25, 1919		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 13240 Catoctin Furnace Road				10f. Zip Code 21788		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry self	
	17. Father's Name (First, Middle, Last) Howard Sweeney				18. Mother's Name (First, Middle, Maiden Surname) Hattie					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Wayne Smith / grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13240 Catoctin Furnace Rd, Thurmont, MD 21788					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Blue Ridge Cemetery		20c. Location - City or Town, State 12/27/99 Thurmont, Maryland			
	21. Signature of Funeral Service Licensee Paul P.B. Mackey				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 104 E. Main Street, Thurmont, MD 21788					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. gangrene left foot										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Robert Kaufman 29c. License number D-13971 29d. Date signed (Month, Day, Year) 12/24/99										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Kaufman, 300 West Ninth Street, Frederick,										
31. Date filed (Month, Day, Year) DEC 27 1999 32. Registrar's Signature B. Smith										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42671

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GARY FRANK SMITH				2. Date of Death Month Day Year December 18, 1999		3. Time of Death 12:38 PM		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 220-32-5218		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 16, 1936		
	9. Birthplace (State or Foreign Country) Wahsington, DC		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 6590 Whetstone Dr.		10f. Zip Code 21703		10g. Citizen of What Country? Untied States	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 54-57		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5 +		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Music Teacher		16b. Kind of Business/Industry County School System					
17. Father's Name (First, Middle, Last) Craig L. Smith, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Harriett M. Kelser					
19a. Informant's Name/Relationship (Type, Print) Jeanne P. Smith / wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6590 Whetstone Dr. / Frederick, Maryland 21703					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		20c. Date 12-23-99		20d. Location - City or Town, State Frederick, Maryland			
21. Signature of Funeral Service Licensee <i>Raymond Peterson</i>				22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute myo. infarction</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <i>1 hr.</i>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Robert L. Kapner</i>				29c. License number D 13971	
				29d. Date signed (Month, Day, Year) 12/21/99					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 W 9th St. Frederick MD 21701									
31. Date filed (Month, Day, Year) DEC 22 1999		32. Registrar's Signature <i>B. Spahr</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42672

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES DONALD SEYBOLT				2. Date of Death Month Day Year December 19, 1999		3. Time of Death 1:36 PM		
	4a. Facility Name (If not institution, give street and number) FREDERICK MEMORIAL HOSPITAL				4b. City, Town, or Location of Death FREDERICK		4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 577-03-6592		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 6, 1912		
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Clarksburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 13809 Lewisdale Road				10f. Zip Code 20871		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Sealtest Dairy			
17. Father's Name (First, Middle, Last) James M. Seybolt				18. Mother's Name (First, Middle, Maiden Surname) Iva Nelson Seybolt					
19a. Informant's Name/Relationship (Type, Print) Margaret L. Seybolt / daughter-in-law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6908 S. Osborne Road, Upper Marlboro, MD 20772					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Gardens		20c. Location - City or Town, State 12/22/99 Frederick, Maryland			
21. Signature of Funeral Service Licensee <i>Paul P. B. Mackay</i>				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Congestive Heart Failure</i> Due to (or as a consequence of): b. <i>Pneumonia</i> Due to (or as a consequence of): c. <i>Aortic Stenosis</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 5 day) 5 day) 5 year)					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Esophageal Cancer</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Austin Pearce Jr.</i>				29c. License number 009689		29d. Date signed (Month, Day, Year) 12/20/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Pearce 300 West Ninth Street, Frederick, Maryland 21702									
31. Date filed (Month, Day, Year) DEC 21 1999		32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Physician
/Medical
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42673

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Edward James Templeton

2. Date of Death

December 21, 1999

3. Time of Death

1:30 AM

4a. Facility Name (If not institution, give street and number)

3512- 2C Thomas Pointe Ct.

4b. City, Town, or Location of Death

Abingdon

4c. County of Death

Harford

5. Social Security Number

116-20-3564

6. Sex

XXM 2 F

7. Age (in yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 28, 1928

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3512 - 2C Thomas Pointe Ct.

10f. Zip Code

21009

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give

Year or Dates: 1945-64

13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Military

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Cecil Romain Templeton

18. Mother's Name (First, Middle, Maiden Surname)

Daisy (u/k) Gordon

19a. Informant's Name/Relationship (Type, Print)

Dorothy R. Templeton, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3512 - 2C Thomas Pointe Ct., Abingdon, Maryland 21009

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Entombment Highview Memorial Gardens 12-23-99 Fallston, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)a. RENAL CELL CARCINOMA
Due to (or as a consequence of):Sequitally list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy
performed?

1 Yes 2 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

1 Yes 2 No

25. Was case referred to medical
examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending
2 Accident 6 investigation
3 Suicide 6 Could not be
4 Homicide 6 determined28e. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of Certifier

29c. License number

038409

29d. Date signed (Month, Day, Year)

12/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM

SHMFMW

10753

Falls Rd,

Lithonia, GA

21093

State
Registrar

31. Date filed (Month, Day, Year)

12 DEC 21 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42674

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Madeline Allen Thompson						2. Date of Death Month Day Year December 22 1999		3. Time of Death 11:55 P.M.													
	4a. Facility Name (If not institution, give street and number) Mariner Health of Forest Hill						4b. City, Town, or Location of Death Forest Hill		4c. County of Death Harford													
Funeral Director	5. Social Security Number 214-22-8921		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) June 30, 1911		9. Birthplace (State or Foreign Country) W. Virginia													
	Usual Residence of Decedent																					
10a. State Maryland		10b. County Harford		10c. City, Town or Location Fallston				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
10e. Street and Number 2214 Watervale Road				10f. Zip Code 21047		10g. Citizen of What Country? USA																
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home															
17. Father's Name (First, Middle, Last) William Leslie Allen						18. Mother's Name (First, Middle, Maiden Surname) Sarah (u/k) Gunnoe																
19a. Informant's Name/Relationship (Type, Print) Shirley M. Mele - Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 911 Monte Avenue, Fallston, Maryland 21047																
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fallston U.M. Church Cem.		Date 12/28/99		20c. Location - City or Town, State Fallston, Maryland														
21. Signature of Funeral Service Licensee Shirley K. McComas						22. Name and Address of Facility McComas Funeral Home, P.A. 50 West Broadway, Bel Air, Maryland 21014																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>electrolyte disturbances</td> <td>Approximate Interval Between Onset and Death CTWK</td> </tr> <tr> <td>b.</td> <td>renal insufficiency</td> <td>CTMO</td> </tr> <tr> <td>c.</td> <td>poor oral intake</td> <td>CTMO</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	electrolyte disturbances	Approximate Interval Between Onset and Death CTWK	b.	renal insufficiency	CTMO	c.	poor oral intake	CTMO	d.		
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	electrolyte disturbances	Approximate Interval Between Onset and Death CTWK																			
	b.	renal insufficiency	CTMO																			
	c.	poor oral intake	CTMO																			
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. dementia disease w/ 2 surgeries C. difficile infection								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier David S. Dunn		29c. License number D3 2277		29d. Date signed (Month, Day, Year) December 27, 1999																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David S. Dunn 615 W. MacPho. /																						
31. Date filed (Month, Day, Year) DEC 29 1999		32. Registrar's Signature Beverly B. Sparks																				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42675

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RUSSELL LEE TAYLOR				2. Date of Death Month Day Year December 29, 1999		3. Time of Death 5:15 P.M.	
	4a. Facility Name (If not institution, give street and number) 2261 Engle Road				4b. City, Town, or Location of Death Fallston		4c. County of Death Harford	
Funeral Director	5. Social Security Number 218-32-3864	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8/29/1919		9. Birthplace (State or Foreign Country) N. Carolina
	Usual Residence of Decedent							
10a. State MD.		10b. County Harford		10c. City, Town or Location Fallston		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 2261 Engle Road				10f. Zip Code 21047		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Caucasian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman		16b. Kind of Business/Industry Farming		
17. Father's Name (First, Middle, Last) Guy McMillan Taylor				18. Mother's Name (First, Middle, Maiden Surname) Sallie Gertrude Brown				
19a. Informant's Name/Relationship (Type, Print) Deborah L. Taylor/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 a,b,c,e,f				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cem. Upper Cross Roads		20c. Location - City or Town, State 2000 Upper Cross Roads, Md.				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? Inspection <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) December 31, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John E. Smialek, M.D. 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) JAN 6 2000		32. Registrar's Signature  JAN 4 2000						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42676

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Crockett Tibbs				2. Date of Death Month Day Year December 30, 1999		3. Time of Death 3:40 AM																	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY																	
Funeral Director	5. Social Security Number 218-24-6923	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	8. Date of Birth (Month, Day, Year) May 1, 1926	9. Birthplace (State or Foreign Country) Virginia																			
	Usual Residence of Decedent																							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Damascus		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
10e. Street and Number 24707 Ridge Road		10f. Zip Code 20872		10g. Citizen of What Country? U.S.A.																				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner-Operator		16b. Kind of Business/Industry Food Service																				
17. Father's Name (First, Middle, Last) James Tibbs				18. Mother's Name (First, Middle, Maiden Surname) Flora Edna Etwell																				
19a. Informant's Name/Relationship (Type, Print) Janet D. Guynn - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24707 Ridge Road, Damascus, Maryland 20872																				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Cemetery		Date 1/3/2000		20c. Location - City or Town, State Laytonsville, Maryland																		
21. Signature of Funeral Service Licensee Robert L. Williams				22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117																				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.																								
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Myocardial Infarction</td> <td>Due to (or as a consequence of):</td> <td>1 day</td> </tr> <tr> <td>b.</td> <td>Respiratory Failure</td> <td>Due to (or as a consequence of):</td> <td>8 days</td> </tr> <tr> <td>c.</td> <td>Chronic Obstructive Pulmonary Disease</td> <td>Due to (or as a consequence of):</td> <td>years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Myocardial Infarction	Due to (or as a consequence of):	1 day	b.	Respiratory Failure	Due to (or as a consequence of):	8 days	c.	Chronic Obstructive Pulmonary Disease	Due to (or as a consequence of):	years	d.			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	Myocardial Infarction	Due to (or as a consequence of):	1 day																				
	b.	Respiratory Failure	Due to (or as a consequence of):	8 days																				
	c.	Chronic Obstructive Pulmonary Disease	Due to (or as a consequence of):	years																				
	d.																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier David Holden M.D.				29c. License number 047791		29d. Date signed (Month, Day, Year) December 30, 1999																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Holden, M.D. 809 Veirs Mill Rd. Rockville, MD 20851																								
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature B. Sparks																						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42677

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HOWARD VERNON TULL				2. Date of Death Month Day Year DECEMBER 27, 1999		3. Time of Death 3:30 AM		
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick		
Funeral Director	5. Social Security Number 210-12-8265		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Aug 21, 1919		
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Thurmont		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 11408 Hessong Bridge Road		10f. Zip Code 21788		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Security		16b. Kind of Business/Industry Federal Government		17. Father's Name (First, Middle, Last) Joseph M Tull		18. Mother's Name (First, Middle, Maiden Surname) Sarah E. Perego	
19a. Informant's Name/Relationship (Type, Print) Janice L. Tull/Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11408 Hessong Bridge Road, Thurmont, MD 21788		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Saint Mary's Cemetery		20c. Location - City or Town, State Dec 30, 1999 Emmitsburg, MD	
21. Signature of Funeral Service Licensee <i>Keith Lynn Roberson</i> M00706		22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. VENTRICULAR ASYSTOLE Due to (or as a consequence of): b. RESPIRATORY ARREST Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death MIN			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATRIAL FIBRILLATION		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>John A. Vitarello MD</i>		29c. License number D27544		29d. Date signed (Month, Day, Year) 12/27/99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John A. Vitarello, MD, 189 Thomas Johnson Drive, #202, Frederick, Maryland 21702		31. Date filed (Month, Day, Year) DEC 28 1999		32. Registrar's Signature <i>B. Spaul</i>					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42678

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Martin Edward WEMPE

2. Date of Death

December 29 1999

3. Time of Death

0945

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

220-10-3284

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JAN. 7 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

911 Frederick Street

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assistant Controller

16b. Kind of Business/Industry

Aircraft

17. Father's Name (First, Middle, Last)

Edward Martin Wempe

18. Mother's Name (First, Middle, Maiden Surname)

May Agnes Firey

19a. Informant's Name/Relationship (Type, Print)

David A. Wolf - Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13306 Unger Road Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rose Hill Cemetery

Date

1/3/2000

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

Scott M. Minnich

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Maryland 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Right lower lobe pneumonia*
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic obstructive pulmonary disease
Diabetes mellitus. Left ventricular dysfunction
Acute gastritis related to alcohol*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward M. Minnich

29c. License number

007857

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Moody 1190 Mt. Aetna Rd. Hagerstown, Md 21740

State
Registrar

31. Date filed (Month, Day, Year)

DEC 30 1999

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42679

Amend item 17 HCHD 12/28/99 Certificate of Death BRH

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ANN P. WEBSTER

2. Date of Death

Dec. 18, 1999

3. Time of Death

10:40 AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

238-05-6830

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/14/1915

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Street

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

4525 Clermont Mill Road

10f. Zip Code

21154

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

George Page Harry Page

18. Mother's Name (First, Middle, Maiden Surname)

Addie Hoover

19a. Informant's Name/Relationship (Type, Print)

Sally Ensor- daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3631 Southside Ave., Phoenix, MD 21131

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

12/21/99

20c. Location - City or Town, State

Pylesville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harkins F.H. Inc., 600 Main St., Delta, PA 17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. END STAGE PARKINSON'S DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

DEC 23 1999

32. Registrar's Signature

B. Sparks

State Registrar

ANN WEBSTER December 18, 1999 10:40 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42680

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EFFIE E WARFIELD				2. Date of Death Month 12 Day 22 Year 99				3. Time of Death 10:53 PM			
	4a. Facility Name (If not institution, give street and number) HARFORD MEM. HOSPITAL				4b. City, Town, or Location of Death Havre de Grace				4c. County of Death HARFORD			
Funeral Director	5. Social Security Number 218-09-9063		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) Sept 10, 1909		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County HARFORD		10c. City, Town or Location Aberdeen				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1500 Mitchell Lane				10f. Zip Code 21001		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) House Keeper - Supervisor			16b. Kind of Business/Industry Civil Service Aberdeen Prov. Ground						
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Lloyd Hollingsworth				18. Mother's Name (First, Middle, Maiden Surname) Emily Parker							
	19a. Informant's Name/Relationship (Type, Print) Emily Johnson - daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Mitchell Lane Aberdeen MD, 21001							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Union United Meth.		Date 12-28-99		20c. Location - City or Town, State Aberdeen, MD					
	21. Signature of Funeral Service Licensee Blaise Scott		22. Name and Address of Facility BEARD Funeral Home 552 Lewis St Havre de Grace, MD, 21078									
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis Due to (or as a consequence of): Dehydration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Anemia										Approximate Interval Between Onset and Death one week one week	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Anemia										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	29b. Signature and title of certifier Dr. Mirza A. BAKAD				29c. License number D4315				29d. Date signed (Month, Day, Year) 12-23-99			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 S. Union Ave, HVD, MD 21078											
	31. Date filed (Month, Day, Year) DEC 27 1999											

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42681

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LAURA M. WYATT

2. Date of Death
Month Day Year

Dec. 29, 1999

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

Calvert Manor Healthcare Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

197-01-9234

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3/24/1907

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Street

10d. Inside City Limits

1 ☐ Yes ☒ No

10a. Street and Number

840 Highland Road

10f. Zip Code

21154

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Ollie Sheets

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Miller

19a. Informant's Name/Relationship (Type, Print)

Elvira W. Petty- daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

840 Highland Rd., Street, MD 21154

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Batist View Cemetery 1/2/2000 Forest Hill, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jeffrey P. Lucidse

22. Name and Address of Facility

Harkins F.H. Inc, 600 Main St., Delta, PA 17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- DEMENTIA

- COPD

- ASCVD

- NP

- CHF

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

28. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. Lucidse MD

29c. License number

D42800

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS A. BRINDO 319 S. UNION AVE, Hd G, Md, 2078

31. Date filed (Month, Day, Year)

DEC 30 1999

32. Registrar's Signature

B. Sparto

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

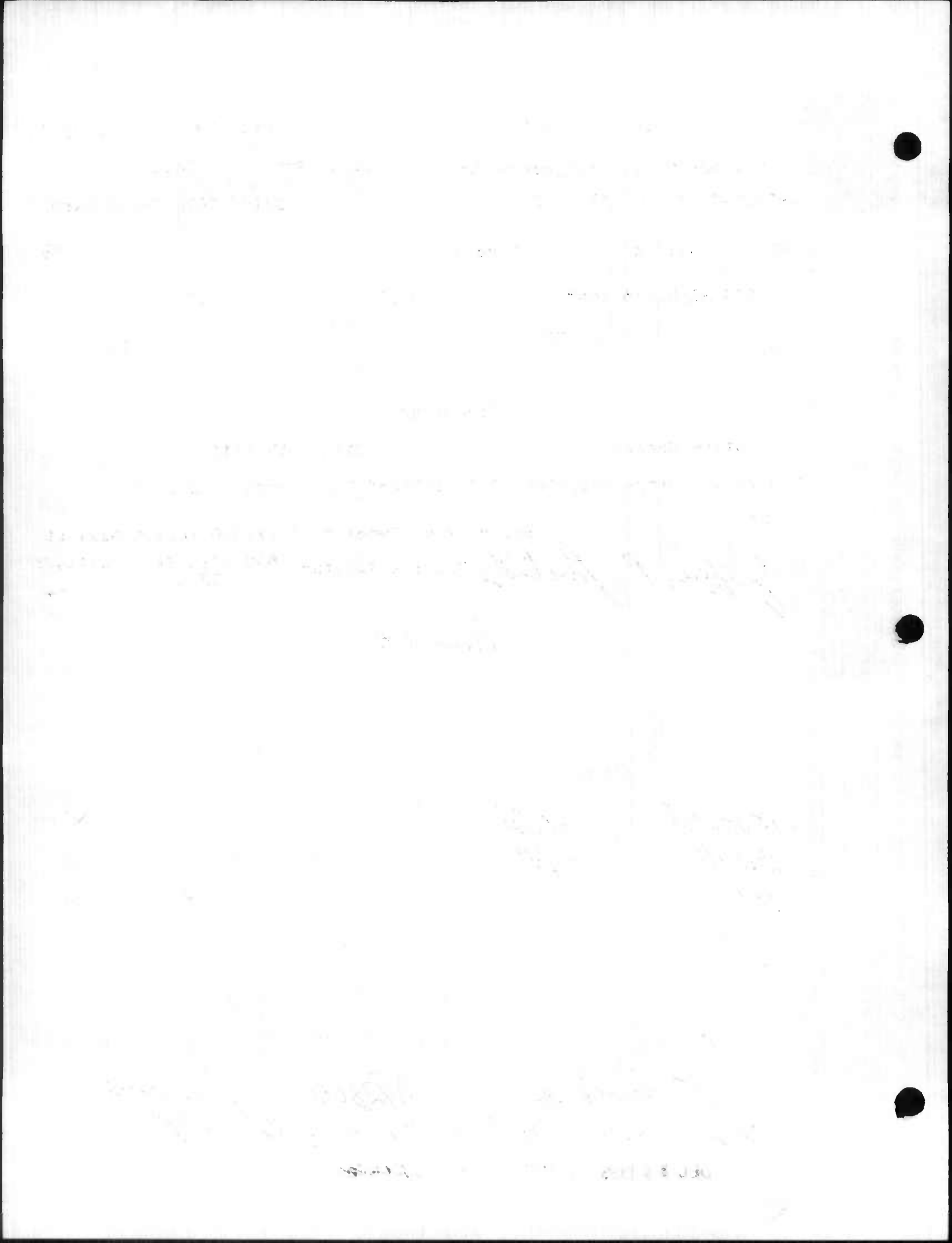
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42682

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Catherine Winpigler

2. Date of Death

December 19, 1999

3. Time of Death

9:00 pm

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

213-24-8095

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 21, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State
Maryland

10b. County

Frederick

10c. City, Town or Location

New Market

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7108 Stretch Court

10f. Zip Code

21774

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

self

16b. Kind of Business/Industry

homemaker

17. Father's Name (First, Middle, Last)

John William Thompson

18. Mother's Name (First, Middle, Maiden Summa)

Bessie Stine

19a. Informant's Name/Relationship (Type, Print)

Debra Bowers, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7106 Stretch Court, New Market, Maryland 21774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet Cemetery

Date

12/23/99

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Keeney and Basford Funeral Home
MO0999 106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral vascular accident

~14 days.

Due to (or as a consequence of):

b. Carotid occlusive Disease

years

Due to (or as a consequence of):

c. Carotid revascularization procedure ~14 days.

Due to (or as a consequence of):

d. Hypertensive cardiovascular disease years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

026499

29d. Date signed (Month, Day, Year)

12-21-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald Miller, MD, PO Box 210, Mt. Airy, MD 21771

31. Date filed (Month, Day, Year)

DEC 22 1999

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42683



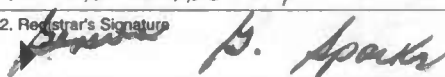
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carolyn Marguerite Zimmerman						2. Date of Death Month Day Year December 23, 1999		3. Time of Death 3:35 PM	
	4a. Facility Name (If not institution, give street and number) Harford Memorial Hospital						4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
Funeral Director	5. Social Security Number 214-22-1250		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) July 6, 1927		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Forest Hill				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1620 B Denise Dr.				10f. Zip Code 21050		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant			16b. Kind of Business/Industry Restaurant		
	17. Father's Name (First, Middle, Last) John Benson Humphrey						18. Mother's Name (First, Middle, Maiden Surname) Anna (nmn) Powers			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Helen N. Leach/ POA				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Forehand Ct., Bel Air, Maryland 21015					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State 12-24-99 Towson, Maryland			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Renal Failure</i> Due to (or as a consequence of): b. <i>CVA/TIA</i> Due to (or as a consequence of): c. <i>Pneumothorax</i> Due to (or as a consequence of): d. <i>ASHD</i>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
State Registrar	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 20053622		29d. Date signed (Month, Day, Year) 12-24-99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEFAN ELTOROTH MD 3125 Univ Ave H&G MD										
31. Date filed (Month, Day, Year) DEC 27 1999		32. Registrar's Signature <i>[Signature]</i>								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42684

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE E. ZEBROSKI				2. Date of Death Month Day Year December 18, 1999		3. Time of Death 7:00 AM														
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick														
Funeral Director	5. Social Security Number 215-34-3710		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) May 26, 1937														
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Woodsboro														
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 10132 Woodsboro Road		10f. Zip Code 21798		10g. Citizen of What Country? United States														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Excavating																
	17. Father's Name (First, Middle, Last) Horace Smith				18. Mother's Name (First, Middle, Maiden Surname) Violet Clary																
	19a. Informant's Name/Relationship (Type, Print) Thomas E. Zebroski / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10132 Woodsboro Road, Woodsboro, Maryland 21798																
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date Dec. 21 1999		20c. Location - City or Town, State Frederick, Maryland														
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702																
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Respiratory Failure</td> <td>24 hours</td> </tr> <tr> <td>b.</td> <td>Pleural Effusions</td> <td>6 months</td> </tr> <tr> <td>c.</td> <td>Ovarian Cancer</td> <td>3 years</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	Respiratory Failure	24 hours	b.	Pleural Effusions	6 months	c.	Ovarian Cancer	3 years	d.		
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b.		Pleural Effusions	6 months																		
c.		Ovarian Cancer	3 years																		
d.																					
<table border="1"> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="3">Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Sepsis</td> </tr> <tr> <td colspan="3">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="3">24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td>24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> </tr> </table>								Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Malnutrition Sepsis			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
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29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier  M.D.				29c. License number D41866		29d. Date signed (Month, Day, Year) December 18, 1999															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KANAN HUDHAUD, MD 801 TOLLHOUSE AVENUE, D3 FREDERICK, MD 21701																					
31. Date filed (Month, Day, Year) DEC 21 1999		32. Registrar's Signature 																			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

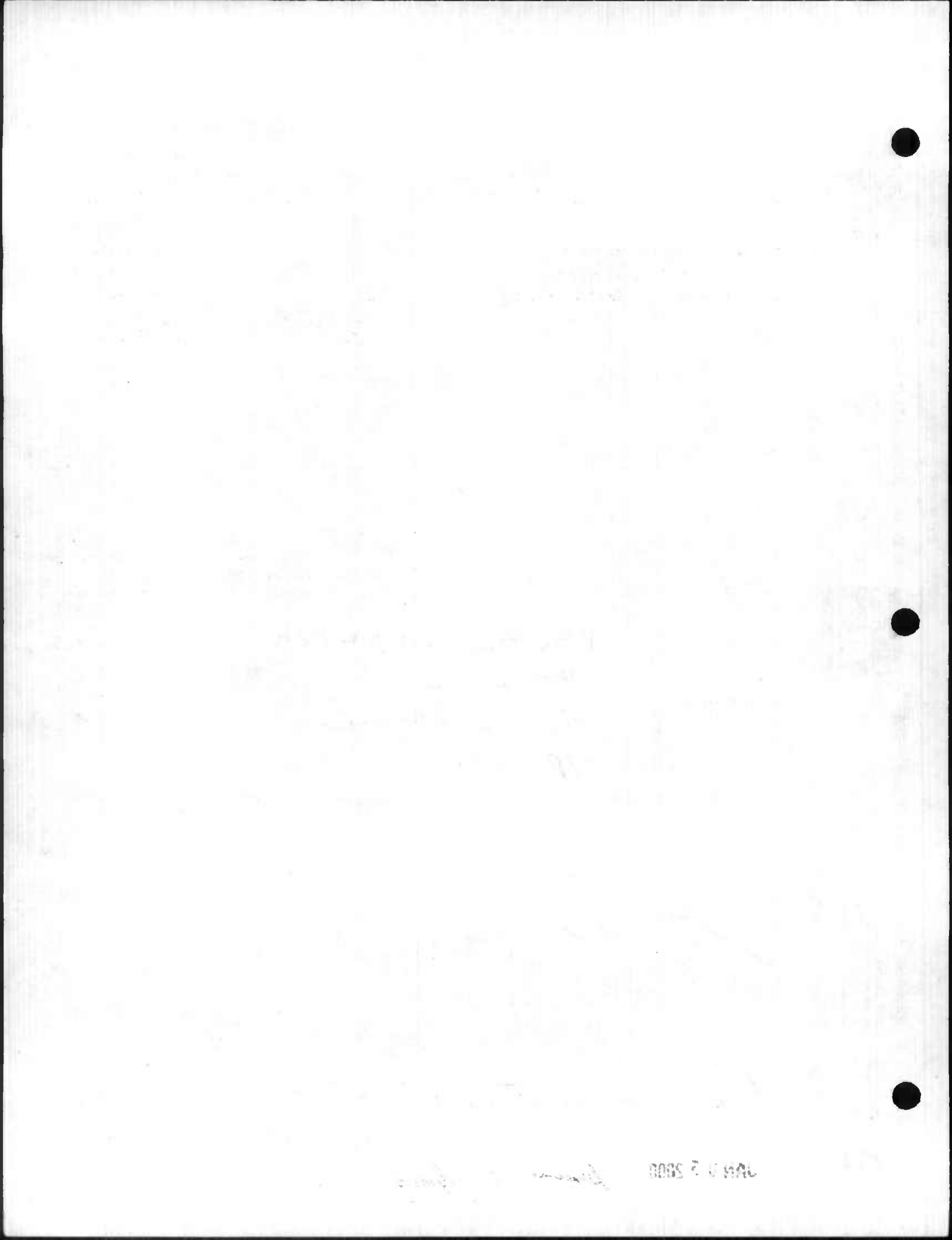
State of Maryland / Department of Health and Mental Hygiene 99 42685

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Virginia Alexander				2. Date of Death Month December Day 30 , Year 1999		3. Time of Death 5:20 A.M.		
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 579-22-7350		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) February 7, 1917		
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Clinton		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 9211 Stuart Lane		10f. Zip Code 20735		10g. Citizen of What Country? United States	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Information Specialist		16b. Kind of Business/Industry US Dept. of Labor		17. Father's Name (First, Middle, Last) (unknown)		18. Mother's Name (First, Middle, Maiden Surname) Irene Alexander	
19a. Informant's Name/Relationship (Type, Print) Lois Renee Hobson (Niece)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10508 Cleary Lane; Bowie, Maryland 20721		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia	
21. Signature of Funeral Service Licensee <i>Robert G. Mason</i>		22. Name and Address of Facility Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E.; Wash. D.C. 20020		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Vomiting & aspiration Due to (or as a consequence of): b. Hypoxemia Due to (or as a consequence of): c. Alzheimer's dementia Due to (or as a consequence of): d. SIP PEG		Approximate Interval Between Onset and Death 12hr 12h 1hr			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi N. Berwa, M.D.; 7700 Old Branch Avenue, Suite C-101; Clinton, Maryland 20735		31. Date filed (Month, Day, Year) JAN 05 2000		32. Registrar's Signature <i>Robert G. Mason</i>					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42686**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Violet Blanche Adams
2. Date of Death Month Day Year December 31, 1999
3. Time of Death 5:42 pm

Funeral
Director

4a. Facility Name (If not institution, give street and number) Asbury/Solomans Retirement Center
4b. City, Town, or Location of Death Solomans Island
4c. County of Death Calvert

5. Social Security Number 578-22-4026
6. Sex 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday) 89 Yrs.
8. Date of Birth (Month, Day, Year) Nov. 17, 1910
9. Birthplace (State or Foreign Country) Virginia

Usual Residence of Decedent

10a. State Maryland
10b. County Calvert
10c. City, Town or Location Solomans Island
10d. Inside City Limits 1 ☒ Yes 2 ☐ No

10e. Street and Number 11750 Asbury Circle - Suite 104
10f. Zip Code 20688
10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12) 12
College (14 or 5+) Collega (14 or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary
16b. Kind of Business/Industry U.S. Government

17. Father's Name (First, Middle, Last) William Thrift
18. Mother's Name (First, Middle, Maiden Surname) Nora Lee Hale

19a. Informant's Name/Relationship (Type, Print) Marjorie R. Hay - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Rabbit Run Lane, Berlin, Maryland 21811

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery
20c. Location - City or Town, State Suitland, Maryland
20d. Date 01/06/00

21. Signature of Funeral Service Licensee
22. Name and Address of Facility Gasch's Funeral Home, P.A.
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia
Due to (or as a consequence of):
b. Dementia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier
29c. License number 042610
29d. Date signed (Month, Day, Year) January 4, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David J. Tardio, M.D. Route 4 Patuxent Plaza, Solomans, Maryland 20688

31. Date filed (Month, Day, Year) JAN 06 2000
32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

GOAL: QUAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42687

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JEAN J. BIGGS

2. Date of Death

December 31 1999

3. Time of Death

10:27AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

578 24 0995

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 5, 1925

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5717 Colon Terr.

10f. Zip Code

20746

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Statistician

16b. Kind of Business/Industry

Census Bureau

17. Father's Name (First, Middle, Last)

Ira E. Biggs

18. Mother's Name (First, Middle, Maiden Surname)

Evla Snyder

19a. Informant's Name/Relationship (Type, Print)

Iris Webber

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11805 College View Drive Wheaton, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Jan. 6, 2000

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RENAL FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-18545

29d. Date signed (Month, Day, Year)

DECEMBER 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. WISOTSKY M.D. 12070 OLD LINE CENTER WALKER, MD. 20602

31. Date filed (Month, Day, Year)

JAN 07 2000

32. Registrar's Signature

B. B. Smith

State
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

Handwritten signature or mark

0003 04AL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42688
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MILDRED PAULINE BLOOM				2. Date of Death Month Day Year December 25 1999		3. Time of Death 5:20 p.m.	
	4a. Facility Name (If not institution, give street and number) Ginger Cove Health Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 471 32 1326	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 29, 1909		9. Birthplace (State or Foreign Country) MN
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 4000 River Crescent Drive				10f. Zip Code 21401		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) X-Ray Technician			16b. Kind of Business/Industry Health Care	
17. Father's Name (First, Middle, Last) George C Binder				18. Mother's Name (First, Middle, Maiden Surname) Selma Amelia Hammerlund				
19a. Informant's Name/Relationship (Type, Print) Paul T. Nast/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Stony Hill Rd., Fredericksburg, VA 22406				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Friendship UM Church Cem		Data 12-30-99		20c. Location - City or Town, State Friendship, MD		
21. Signature of Funeral Service Licensee William R. Jones				22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD				
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death one day
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Septic Arthritis						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Robert A. Miller MD				29c. License number 031778		29d. Date signed (Month, Day, Year) December 27, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert A. Miller MD 2003 Medicine Parkway Annapolis, MD 21401								
31. Date filed (Month, Day, Year) DEC 30 1999		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42689

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Baker				2. Date of Death Month December Day 30 Year 1999		3. Time of Death 8:06 P.M.		
	4a. Facility Name (If not Institution, give street and number) 45939 Halsey Court				4b. City, Town, or Location of Death California		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 218-38-6533		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 57 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 25, 1942		
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland 10b. County St. Mary's 10c. City, Town or Location California 10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1963-1966		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Van Driver		16b. Kind of Business/Industry Tri County Youth Serv.	
17. Father's Name (First, Middle, Last) Harold Baker				18. Mother's Name (First, Middle, Maiden Surname) Sarah Evelyn Gant				19. Informant's Name/Relationship (Type, Print) Sarah Evelyn Hewlett/Mother	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter Claver Cem.		20c. Location - City or Town, State 1/6/00 St. Inigoes, MD		21. Signature of Funeral Service Licensee Black G. Sewell	
22. Name and Address of Facility Sewell Funeral Home				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Resp arrest Due to (or as a consequence of): Cardiac arrest Due to (or as a consequence of): Metastatic Cancer Due to (or as a consequence of): Liver met				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier Dr. Shah MD				29c. License number D 50290				29d. Date signed (Month, Day, Year) 1-3-2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhiren Shah, M.D.				31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature B. Sparks	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42690

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

James Wallace Baken

2. Date of Death

Month

Day

Year

December 30, 1999

3. Time of Death

6:20 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-56-6555

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
02-05-1943

9. Birthplace (State or Foreign Country)

Washington, DC.

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

100 55th Street, S.E.

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Ernest Baken

18. Mother's Name (First, Middle, Maiden Surname)

Ella Lee (unk)

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Baken (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 55th Street, SE. Washington, D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

1/6/00

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pope Funeral Homes, 5538 Marlboro Pike

Forestville, Maryland 20748

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Diabetes

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cellulitis Right Leg

Anemia

Depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

N/A

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D34472

29d. Date signed (Month, Day, Year)

December 31, 1999

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

Lynne Diggs, MD. 1500 Forest Glen Road, Silver Spring, Maryland

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

Anne B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42691

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Samuel Calvin Boothe

2. Date of Death

Month Day Year
DECEMBER 29 1999

3. Time of Death

12:03 PM

4a. Facility Name (If not institution, give street and number)

Doctor's Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

229-40-1812

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec 5, 1932

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Seabrook

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9410 Franklin Ave.

10f. Zip Code

20706

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Coleman-Woods Const.

17. Father's Name (First, Middle, Last)

Walter Boothe

18. Mother's Name (First, Middle, Maiden Summa)

Virgie Belcher

19a. Informant's Name/Relationship (Type, Print)

Laura F. Boothe (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9410 Franklin Ave. Seabrook, MD 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

MD Veterans Cemetery

Date

20c. Location - City or Town, State

Cheltenham, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home
9013 Annapolis Rd. Lanham, MD 2070623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. END STAGE CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CARDIOMYOPATHY

Due to (or as a consequence of):

c. VENTRICULAR TACHYCARDIA

Due to (or as a consequence of):

d. CORONARY ARTERY DISEASE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERLIPIDEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Rao MD

29c. License number

20757

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aroor S. Rao 8100 Good Luck Rd Suite 302 Lanham Md 20706

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

A. Rao

State
Registrar

ORIGINAL

SAMUEL BOOTHE
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5

1954-1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42692

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Connie L. Bell				2. Date of Death Month Day Year DECEMBER 26, 1999				3. Time of Death 1259						
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY				4c. County of Death PRINCE GEORGES						
Funeral Director	5. Social Security Number 577-52-2623		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) July 4, 1927		9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent														
10a. State Maryland		10b. County Prince Georges'		10c. City, Town or Location Bladensburg						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 5999 Emerson Street				10f. Zip Code 20710				10g. Citizen of What Country? United States							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home							
17. Father's Name (First, Middle, Last) Joseph Bazemore								18. Mother's Name (First, Middle, Maiden Surname) Bertha Bazemore							
19a. Informant's Name/Relationship (Type, Print) Raymond Bell, Jr./ Son								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4826 Russell Avenue, Hyattsville, Maryland 20782							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery				Date 1-4-00		20c. Location - City or Town, State Brentwood, Maryland					
21. Signature of Funeral Service Licensed Lisa S. Johnson								22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														Approximate interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS												23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier MARIO F. GOLUB JR. MD								29c. License number D32254				29d. Date signed (Month, Day, Year) DECEMBER 27, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLUB JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785															
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature B. Spauld											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CONFIDENTIAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42693

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phillip Dale Barton				2. Date of Death Month Day Year December 28, 1999				3. Time of Death 10:30 AM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 213-46-6555		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Aug. 13, 1944		9. Birthplace (State or Foreign Country) Arizona		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland				10b. County Prince George's				10c. City, Town or Location Bowie	
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 3911 York Lane				10f. Zip Code 20715	
To Be Completed by Physician/Medical Examiner	10g. Citizen of What Country? United States				11. Marital Status XXX <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+	
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman				16b. Kind of Business/Industry Self Employed				17. Father's Name (First, Middle, Last) Lewis Dale Barton	
	18. Mother's Name (First, Middle, Maiden Surname) Susan Irene Patterson				19a. Informant's Name/Relationship (Type, Print) Lewis Barton/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 York Lane Bowie, MD 20715	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens				20c. Location - City or Town, State Davidsonville, MD	
	21. Signature of Funeral Service Licensee Todd Liller				22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Road Bowie, MD 20715				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial infarction Due to (or as a consequence of): Bacterial Sepsis Due to (or as a consequence of): Spinal Abscess	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Dr. [Signature] MD				29c. License number D38445	
	29d. Date signed (Month, Day, Year) Dec 28, 1999				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira W. [Signature] 600 Ridgely Ave, Annapolis, MD 21401				31. Date filed (Month, Day, Year) JAN 03 2000	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature [Signature]				33. State Registrar JAN 03 2000				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	
	35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				36. To Be Completed by Physician/Medical Examiner				37. To Be Completed by Physician/Medical Examiner	

For this

Handwritten signature

0005 & 0 HAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42694

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY GLENDORA BLACKMAN				2. Date of Death Month Day Year December 31 1999		3. Time of Death 7:45 AM	
	4a. Facility Name (If not institution, give street and number) Magnolia Gardens Nursing Home				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 067-70-2011		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) April 25, 1914	
	9. Birthplace (State or Foreign Country) Guyana, So. America		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Mitchellville	
To Be Completed by Funeral Director	10e. Street and Number 11550 Waesche Drive		10f. Zip Code 20721		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) Aubrey Bishop				18. Mother's Name (First, Middle, Maiden Surname) Unknown			
	19a. Informant's Name/Relationship (Type, Print) Clem Jones/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11550 Waesche Drive, Mitchellville, Maryland 20721			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		20c. Location - City or Town, State Landover, Maryland		20d. Date 01/03 2000	
	21. Signature of Funeral Service Licensee Nancy A. Perentie				22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial infarction Due to (or as a consequence of): b. arteriosclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 10 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes mellitus Hypertension							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier R. Sakher M.D.		29c. License number D 26492		29d. Date signed (Month, Day, Year) 12/31/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riad Sakher M.D. 4000 Mitchellville Rd Bowie, MD 20716								
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature B. Spahr						

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42695

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VERA, CHAVIS

2. Date of Death

Month Day Year
December 27, 1999

3. Time of Death

18:05 PM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

243-42-9601

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month Day Year)
May 18, 1929

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State
Md.10b. County
Baltimore10c. City, Town or Location
Catonsville10d. Inside City Limits
☒ Yes ☐ No

10e. Street and Number

2210 Frederick Rd.

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian,

Alaskan, Native Hawaiian,
or other Pacific Islander
Specify: INDIAN

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

0 College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Press Operator

16b. Kind of Business/Industry

Waverly Publishing Co.

17. Father's Name (First, Middle, Last)

Jasper Bell

18. Mother's Name (First, Middle, Maiden Surname)

Edna Locklear

19a. Informant's Name/Relationship (Type, Print)

Eli Chavis / spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS 10e

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LUMBEE MEMORIAL GARDENS

Date

DEC. 31, 1999 LUMBERTON, NC

21. Signature of Funeral Service Licensee

Michael L. Bigler

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cirrhosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatitis C infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural
☐ Accident
☐ Suicide
☐ Homicide
☐ Pending investigation
☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael L. Bigler

29c. License number

P13363

29d. Date signed (Month, Day, Year)

December 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Braun 22 S. Greene St. Baltimore Md 21201

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Jones

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Robert A. Gifford

2000

2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42696

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BOBBY RAY CRAWLEY

2. Date of Death

Month
Dec

Day

30

Year

1999

3. Time of Death

12 noon

4a. Facility Name (If not institution, give street and number)

Bon Secours Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral
Director

5. Social Security Number

224-48-5970

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 26, 1938

9. Birthplace (State or Foreign Country)

Halifax, Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore, Md.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

St. James Terrace #827

10f. Zip Code

21712

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Presto Plate

17. Father's Name (First, Middle, Last)

Eddie Lee Crawley

18. Mother's Name (First, Middle, Maiden Surname)

Okary Adams

19a. Informant's Name/Relationship (Type, Print)

Louise McCoy (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3302 Tanners Way #H Richmond, Va. 23224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cross Rd. Church

Date

1-5-00

20c. Location - City or Town, State

Turberville, VA

21. Signature of Funeral Service Licensee

Dunn & Sons Funeral Service

22. Name and Address of Facility

Dunn & Sons Funeral Service

5635 Eads St, N.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aortic Stenosis

Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL Disease

Diabetes mellitus

Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert C. Greenwell MD

29c. License number

D34334

29d. Date signed (Month, Day, Year)

JAN 3 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT C. GREENWELL JR. MD

315 N. CALVERT ST. Baltimore, MD

21202

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

B. Jones

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000000

0005 1 0 MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42697

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Elaine Cleaver				2. Date of Death Month Day Year Dec 30, 1999				3. Time of Death 8:00 am		
	4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL CENTER				4b. City, Town, or Location of Death LAPLATA				4c. County of Death CHARLES		
Funeral Director	5. Social Security Number 579-30-5356		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) February 25, 1926		9. Birthplace (State or Foreign Country) Michigan		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Charles		10c. City, Town or Location Port Tobacco				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 7385 Simms Landing Road				10f. Zip Code 20677				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant				16b. Kind of Business/Industry Marriott Corporation			
17. Father's Name (First, Middle, Last) Ira Edward LaLonde				18. Mother's Name (First, Middle, Maiden Sumama) Mary Bessie Wood							
19a. Informant's Name/Relationship (Type, Print) Don H. Cleaver / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7385 Simms Landing Road, Port Tobacco, Maryland 20677							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 01/05/00		20c. Location - City or Town, State Brentwood, Maryland			
21. Signature of Funeral Service Licensee ► Claudette J. Dasch				22. Name and Address of Facility Gasch's Funeral Home, P.A., 4739 Baltimore Avenue, Hyattsville, MD 20781							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) s. SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION INTERSTITIAL LUNG DISEASE EMPHYSEMA								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier ► V. Anumangandla				29c. License number D-26064		29d. Date signed (Month, Day, Year) 12-30-99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anumangandla Vidyasagar, M.D. P.O. Box 282 Charlotte Hall, MD 20622											
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature B. Sparks							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42698

Certificate of Death

Reg. No.

Amend # 31. P.G.CO. 1-4-00 cr

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Bernard Francis Dent

2. Date of Death

Month Day Year
December 30 1999

3. Time of Death

9:53AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-01-2955

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Feb. 1, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4537 Eads Place, N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Box Maker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

James D. Dent

18. Mother's Name (First, Middle, Maiden Summa)

Eliza Blair

19a. Informant's Name/Relationship (Type, Print)

William E. Christian - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 Scheerer Ave., Newark, N.J. 07112

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Forest Hills Cemetery

Date

1/8/2000

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Cardiac Arrest
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Myocardial infarction
Due to (or as a consequence of):c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

D 20129

29d. Date signed (Month, Day, Year)

12/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. A. CHACKO MD, 7610 Carroll Ave. # 390, Takoma Park, MD 20912

State
Registrar

31. Date filed (Month, Day, Year)

12/30/99 JAN 04 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

GOODS & MAIL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Michael Jeffrey Dickens

Certificate of Death

Reg. No.

99 42699

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael Jeffrey Dickens		2. Date of Death Month: December Day: 31 Year: 1999		3. Time of Death 09:45 AM
	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death -
Funeral Director	5. Social Security Number none	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 24	8. Date of Birth (Month, Day, Year) Dec. 7, 1999	
	9. Birthplace (State or Foreign Country) MD		10. Usual Residence of Decedent		
10a. State MD		10b. County Calvert		10c. City, Town or Location Prince Frederick	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 108 Helena Drive		10f. Zip Code 20678	
10g. Citizen of What Country? USA		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 0 College (1-4 or 5+): none	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none		16b. Kind of Business/Industry -		17. Father's Name (First, Middle, Last) Jeffrey Alan Dickens	
18. Mother's Name (First, Middle, Maiden Summa) Angela Lynn Sigona		19a. Informant's Name/Relationship (Type, Print) Jeffrey A. Dickens (father)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Mem. Gardens		20c. Location - City or Town, State 1-4-00 Dunkirk, MD	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Severe Pulmonary Hypertension Due to (or as a consequence of): c. Congenital Diaphragmatic Hernia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 24 days 24 days 24 days			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Josephine Lok M.D.</i>		29c. License number RE-S-000	
29d. Date signed (Month, Day, Year) December 31, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Josephine Lok, Johns Hopkins Hospital, 600 N. Wolfe St., Baltimore, MD		31. Date filed (Month, Day, Year) JAN 04 2000	
32. Registrar's Signature <i>B. Sparks</i>		33. Registrar's Title 21287			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42700

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA LOUISE DEBLEY

2. Date of Death

December 29 1999

3. Time of Death

11:59am

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

579 40 0266

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar 4, 1906

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

North Beach

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1068 Walnut Avenue

10f. Zip Code

20714

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

advertising clerk

16b. Kind of Business/Industry

department store

17. Father's Name (First, Middle, Last)

Clarence Lee Miller

18. Mother's Name (First, Middle, Maiden Surname)

Florence Belle Hopwood

19a. Informant's Name/Relationship (Type, Print)

Saralee Debley / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1125 Wisteria Drive, Wildwood, FL 34785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

01-05-00

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

William R. Jones

22. Name and Address of Facility

Rausch Funeral Home, P.A., Owings, MD 20736

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Ventricular tachycardia

b.

Due to (or as a consequence of):

Aortic stenosis

c.

Due to (or as a consequence of):

Long history of coronary artery disease

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D - 45737

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nirmaladevi Gurusamy, MD

6 Post Office Road, Suite 103
Waldorf, Maryland 20602State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

[Signature]

ORIGINAL

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Virginia Debley
Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42701

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ervin DeVere Ellison III				2. Date of Death Month Day Year DECEMBER 30, 1999				3. Time of Death 0014	
	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL				4b. City, Town, or Location of Death FORT WASHINGTON				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 126-07-9362		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) June 27, 1921		9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Fort Washington	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2104 Trafalgar Dr.		10f. Zip Code 20744		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No WWII & Korea-1981		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Military Chaplain		16b. Kind of Business/Industry Federal Government					
	17. Father's Name (First, Middle, Last) Ervin DeVere Ellison II		18. Mother's Name (First, Middle, Maiden Surname) Leora Leonard		19a. Informant's Name/Relationship (Type, Print) Lenore W. Ellison/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2104 Trafalgar Dr., Ft. Washington, MD 20744			
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem. 1/11/2000 Arlington, VA		20c. Location - City or Town, State		20d. Date			
	21. Signature of Funeral Service Licensee George P. Kalas		22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number D33954		29d. Date signed (Month, Day, Year) DECEMBER 31, 1999			
State Registrar	30. Name and address of person who completed cause of death (Item 28a) (Type, Print) MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY MARYLAND 20785		31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature [Signature]					

2000 2 0 KAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42702

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BEVERLY EDMONDS

2. Date of Death

Month Day Year
DECEMBER 26 1999

3. Time of Death

1050 AM

4a. Facility Name (If not institution, give street and number)

HEARTLAND OF HYATTSVILLE

4b. City, Town, or Location of Death

HYATTSVILLE

4c. County of Death

PRINCE GEORGE

Funeral
Director

5. Social Security Number

578 12 9140

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
3/26/20

9. Birthplace (State or Foreign Country)

PACES VA.

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE

10c. City, Town or Location

HYATTSVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6500 RIGGS ROAD

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
10

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

GOVT.

17. Father's Name (First, Middle, Last)

TOMMIE LEE EDMONDS

18. Mother's Name (First, Middle, Maiden Surname)

ANNA JONES

19a. Informant's Name/Relationship (Type, Print)

JAMES EDMONDS SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1391 MORRIS RD. SE# 401 WASH., DC. 20032

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD. VETERANS CEMETERY

Date

1/5/00

20c. Location - City or Town, State

CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee

Keith A. Savage MD 85

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES
5538 Marlboro Pike, Forestville, MD. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANTERIOR WALL MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Vascular Dementia - Vegetative State

Cerebral infarction

Multiple decubitus ulcers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

Paul A. DeVore

29c. License number

D01852

29d. Date signed (Month, Day, Year)

DECEMBER 26 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

31. Date filed (Month, Day, Year)

JAN 07 2000

32. Registrar's Signature

Beverly S. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42703

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel V. Flickinger						2. Date of Death Month Day Year December 30, 1999		3. Time of Death Approx 8AM	
	4e. Facility Name (If not institution, give street and number) Look About Manor Nursing Home						4b. City, Town, or Location of Death Westminster, MD		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 176-05-3456		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) June 4, 1902		9. Birthplace (State or Foreign Country) Carroll Cty., MD	
	Usual Residence of Decedent									
10a. State Pennsyl.		10b. County York		10c. City, Town or Location Hanover, PA 17331				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 414 W. Walnut St., Hanover PA				10f. Zip Code 17331		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrative Receptionist			16b. Kind of Business/Industry Hospital			
17. Father's Name (First, Middle, Last) John Hoffman						18. Mother's Name (First, Middle, Maiden Surname) Mary Corbin				
19a. Informant's Name/Relationship (Type, Print) Earl Palmer/Nephew						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 Bollinger Rd., Westminster, MD 21157				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Olivet Cemetery		Date 1/3/2000		20c. Location - City or Town, State Hanover, PA 17331		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Kenworthy Funeral Home, Inc. 269 Frederick St., Hanover, PA 17331				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILURE Due to (or as a consequence of): CHF Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number 10000 577		29d. Date signed (Month, Day, Year) 1/30/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan M. Bollinger, 125 Airport Dr., Westminster, MD 21157										
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42704

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

STANLEY T. FITZGERALD

2. Date of Death

Month Day Year
DECEMBER 25, 1999

3. Time of Death

1414

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

5. Social Security Number

579-70-9286

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

39

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
December 23, 1960

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

14209 Clayton Street

10f. Zip Code

20853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
10 Yes 20 No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6yrs.

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Quality Assurance

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Walter Fitzgerald

18. Mother's Name (First, Middle, Maiden Surname)

Lois Jones

19a. Informant's Name/Relationship (Type, Print)

Darlene Clyburn/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14209 Clayton Street, Rockville, Maryland 20853

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Chesapeake Crematory

Date

12/31
1999

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

J. A. B.

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. PULMONARY HYPERTENSION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?
10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending
20 Accident investigation
30 Suicide 60 Could not be
40 Homicide determined28a. Date of Injury
(Month, Day Year)28b. Time of
injury28c. Injury at
Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated

29b. Signature and title of certifier

J. A. B.

29c. License number

033954

29d. Date signed (Month, Day, Year)

DECEMBER 29, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARIO F. GOLUE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25



2005 2 04 14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42705

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Thelma M. Francis

2. Date of Death

Month Day Year
December 30, 1999

3. Time of Death

3:20 p.m.

4a. Facility Name (If not institution, give street and number)

4800 Fox Street

4b. City, Town, or Location of Death

College Park

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-24-8664

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
June 9, 1924

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7706 Frederick Road

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Day Care

17. Father's Name (First, Middle, Last)

Francis A. Morris

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Mahoney

19a. Informant's Name/Relationship (Type, Print)

Theresa F. Tucker - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8901 Dayton Avenue, North Beach, MD 20714

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Resurrection Cemetery

Date

01/03/00

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Claudette J. Dash

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Hepatic Insufficiency

Approximate
Interval Between
Onset and Death

3 Months

Due to (or as a consequence of):

b. Metastatic Malignant Melanoma

12 Months

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Sister's Home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury et
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Martin David Weltz

29c. License number

D23743

29d. Date signed (Month, Day, Year)

December 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin David Weltz, M.D. 7525 Greenway Center Drive #205, Greenbelt, MD 20770

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

Sharon B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

7410 4 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend # 20b. & 20c. Per Fam.PGC 1-10-2000

Certificate of Death

Reg. No.

99 42706

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AMANDA C. GREEN

2. Date of Death

Month Day Year
December 29, 1999

3. Time of Death

2:55PM

4a. Facility Name (If not institution, give street and number)

Mariner Health Care

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

579-24-3458

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 15, 1918

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

District of Columbia

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2700 Jasper St., S.E.

10f. Zip Code

20020

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Arthur Bonds

18. Mother's Name (First, Middle, Maiden Surname)

Clara Riser

19a. Informant's Name/Relationship (Type, Print)

Stephanie Green - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4163 Southern Ave., #201, Capitol Heights, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park
~~Glenwood Cemetery~~

Date

1/7/2000

20c. Location - City or Town, State

Hyattsville, Md.
~~Wash., D.C.~~

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of):

c. CHF

Due to (or as a consequence of):

d. Seizure

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Quadriplegia

Bronchial Asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0024208

29d. Date signed (Month, Day, Year)

December 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abulhasan U. Ansari, M.D. 8926 Woodyard Rd., Suite 101; Clinton, MD 20736

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

5

State
Registrar

JAN 4 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42707**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Donald Gray** 2. Date of Death **December 28, 1999** 3. Time of Death **3:20 P.M.**

Funeral
Director

4a. Facility Name (If not Institution, give street and number) **4501 Bishop Carroll Drive** 4b. City, Town, or Location of Death **Upper Marlboro** 4c. County of Death **Prince George's**

5. Social Security Number **213-44-4653** 6. Sex **1 ☒ M 2 ☐ F** 7. Age (In yrs. last birthday) **55** Yrs. 8. Date of Birth (Month, Day, Year) **Dec. 6, 1944** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent

10a. State **Maryland** 10b. County **Prince George's** 10c. City, Town or Location **Upper Marlboro** 10d. Inside City Limits **1 ☐ Yes 2 ☒ No**

10e. Street and Number **4501 Bishop Carroll Drive** 10f. Zip Code **20772** 10g. Citizen of What Country? **USA**

11. Marital Status **1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced** 12. Was Decedent Ever in U.S. Armed Forces? **1 ☒ Yes 2 ☐ No** **1966-** If Yes, Give Year or Dates: **1968** 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) **1 ☐ Yes 2 ☒ No** Specify: 14. Race - American Indian, Black, White, etc. Specify: **Black**

15. Decedent's Education (Specify only highest grade completed) **Elementary/Secondary (0-12) 12** **College (1-4 or 5+)** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Laborer** 16b. Kind of Business/Industry **Construction**

17. Father's Name (First, Middle, Last) **Russell Gray** 18. Mother's Name (First, Middle, Maiden Surname) **Rebecca Bowie**

19a. Informant's Name/Relationship (Type, Print) **Veronica Gray/Wife** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **4501 Bishop Carroll Dr. Upper Marlboro, MD 20772**

20a. Method of Disposition **1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)** 20b. Place of Disposition (Name of cemetery, crematory or other place) **Maryland Veterans' Cem.** Date **1/4/00** 20c. Location - City or Town, State **Cheltenham, MD**

21. Signature of Funeral Service Licensee **Bladen G. Sewell** 22. Name and Address of Facility **Sewell Funeral Home** **1451 Dares Beach Rd. Prince Frederick, MD 20678**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Metastatic Prostate Cancer** Approximate Interval Between Onset and Death **1 year**

Immediate Cause (Final disease or condition resulting in death) **Metastatic Prostate Cancer**

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last **Malnutrition** **Stage III Decubitus Ulcer**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Malnutrition** **Stage III Decubitus Ulcer**

23b. Did tobacco use contribute to the cause of death? **1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown**

24a. Was an autopsy performed? **1 ☐ Yes 2 ☒ No** 24b. Were autopsy findings available prior to completion of cause of death? **1 ☐ Yes 2 ☐ No**

25. Was case referred to medical examiner? **1 ☐ Yes 2 ☒ No** 26. Place of Death (Check only one) **Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)**

27. Manner of Death **1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined** 28a. Date of Injury (Month, Day, Year) **N/A** 28b. Time of Injury **N/A** M 28c. Injury at Work? **1 ☐ Yes 2 ☒ No** 28d. Describe how injury occurred **N/A** 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **N/A** 28f. Location (Street and Number or Rural Route Number, City or Town, State) **N/A**

29a. Certifier (Check only one) **2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.**

29b. Signature and title of certifier **Emerson L. Coronel MD** 29c. License number **D0051194** 29d. Date signed (Month, Day, Year) **12/30/99**

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) **Emerson L. Coronel MD** **5001 Silver Hill Rd, Suitland MD 20746**

31. Date filed (Month, Day, Year) **JAN 03 2000** 32. Registrar's Signature **B. Sparks**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

541

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42708

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Deborah Ann Gross			2. Date of Death Month Day Year DECEMBER 28 1999		3. Time of Death 3:23 AM		
	4e. Facility Name (If not institution, give street and number) St. Mary's Hospital			4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 214-58-1375		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 49 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 14, 1950	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Dameron	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1441 Holland Manor Drive		10f. Zip Code 20628		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Oyster Shucker		16b. Kind of Business/Industry Seafood			
	17. Father's Name (First, Middle, Last) William Alexander Broome		18. Mother's Name (First, Middle, Maiden Surname) Coreatha Dorsey		19a. Informant's Name/Relationship (Type, Print) Melvin Gross/Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 174 Ridge, MD 20680	
Physician /Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ernestine Jones Cemetery		20c. Location - City or Town, State Chesapeake Beach, MD		20d. Date 1/4/00	
	21. Signature of Funeral Service Licensee Blacks G. Sewell		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678		23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cancer of The Breast Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death Months	
To Be Completed by Physician/Medical Examiner	23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier William D. Boyd II M.D.		29c. License number D14285		29d. Date signed (Month, Day, Year) 12-30-99	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM D. BOYD II M.D. 25365 POINT LOOKOUT ROAD LEONARDTOWN, MD. 20650		31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature Benjamin B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as above.

DEBORAH GROSS
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42709

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Louise

Harmon

2. Date of Death

December 22, 1999

3. Time of Death

8:45 PM

4a. Facility Name (If not institution, give street and number)

Salisbury Center: Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, MD

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

222-05-4939

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

8-13-08

9. Birthplace (State or Foreign Country)

VA.

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2nd Street

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Second grade

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Line-worker

16b. Kind of Business/Industry

factory

17. Father's Name (First, Middle, Last)

George Brown

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

Neal Westcott

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

C-1 Apt, Meadows Apt, Pocomoke md, 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Friendship Church Ceme. 12-29-99 Watrouille VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bernie Smith Funeral Home
P.O. Box 331 Pocomoke City, md 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Anterior Myocardial Infarction 22 Aggs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Urinary Tract Infection

Renal Diabetes

Hypertension PVD SIP BKA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D39813

29d. Date signed (Month, Day, Year)

12/23/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Markins MD 1104 Healthway Prime Sales MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

JAN 07 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42710

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald Maurice Henry				2. Date of Death Month Day Year December 29 1999				3. Time of Death 2:34PM	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital Center				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-66-7631		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) May 14, 1949		9. Birthplace (State or Foreign Country) Wash., D.C.	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Laurel				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 12306 Snowden Woods Rd.				10f. Zip Code 20708		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: African American		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physician - Cardiologist			16b. Kind of Business/Industry Self Employed			
17. Father's Name (First, Middle, Last) Joseph L. Henry, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Gloria Ann Hill				
19a. Informant's Name/Relationship (Type, Print) Barbara W. Henry, M.D./Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12306 Snowden Woods Rd., Laurel, MD 20708						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 1/6/2000		20c. Location - City or Town, State Landover, MD		
21. Signature of Funeral Service Licensee <i>John T. Stewart, III</i>				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Systemic Inflammatory Response Syndrome</i> Due to (or as a consequence of): b. <i>Sepsis</i> Due to (or as a consequence of): c. <i>Chronic Liver Disease</i> Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure.</i>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. Signature and title of certifier <i>James Catarenis</i>				29c. License number D30318		29d. Date signed (Month, Day, Year) 12/29/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. James Catarenis, 3001 Hospital Drive, Cheverly, MD 20785										
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature <i>B. Spats</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15

State
Registrar

and the

DOES & CIAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42711

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rena Louise Hamilton				2. Date of Death Month Day Year DECEMBER 29, 1999		3. Time of Death 0929		
	4a. Facility Name (If not institution, give street and number) 4215 TORQUE STREET				4b. City, Town, or Location of Death CAPITOL HEIGHTS		4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number 577-74-1325		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 15, 1922	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capitol Heights			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 4215 Torque St.				10f. Zip Code 20743		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Worker			16b. Kind of Business/Industry Private		
17. Father's Name (First, Middle, Last) Robert Harper				18. Mother's Name (First, Middle, Maiden Summa) Sarah Colbert					
19a. Informant's Name/Relationship (Type, Print) Alice E. Addison - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Oak St., Upper Marlboro, MD 20772					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Cem.		20c. Location - City or Town, State 1/5/2000 Suitland, MD			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019					
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediata Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number P33954		29d. Date signed (Month, Day, Year) DECEMBER 29, 1999			
30. Name and address of person who completed cause of death (from 23a) (Type, Print) MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785									
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

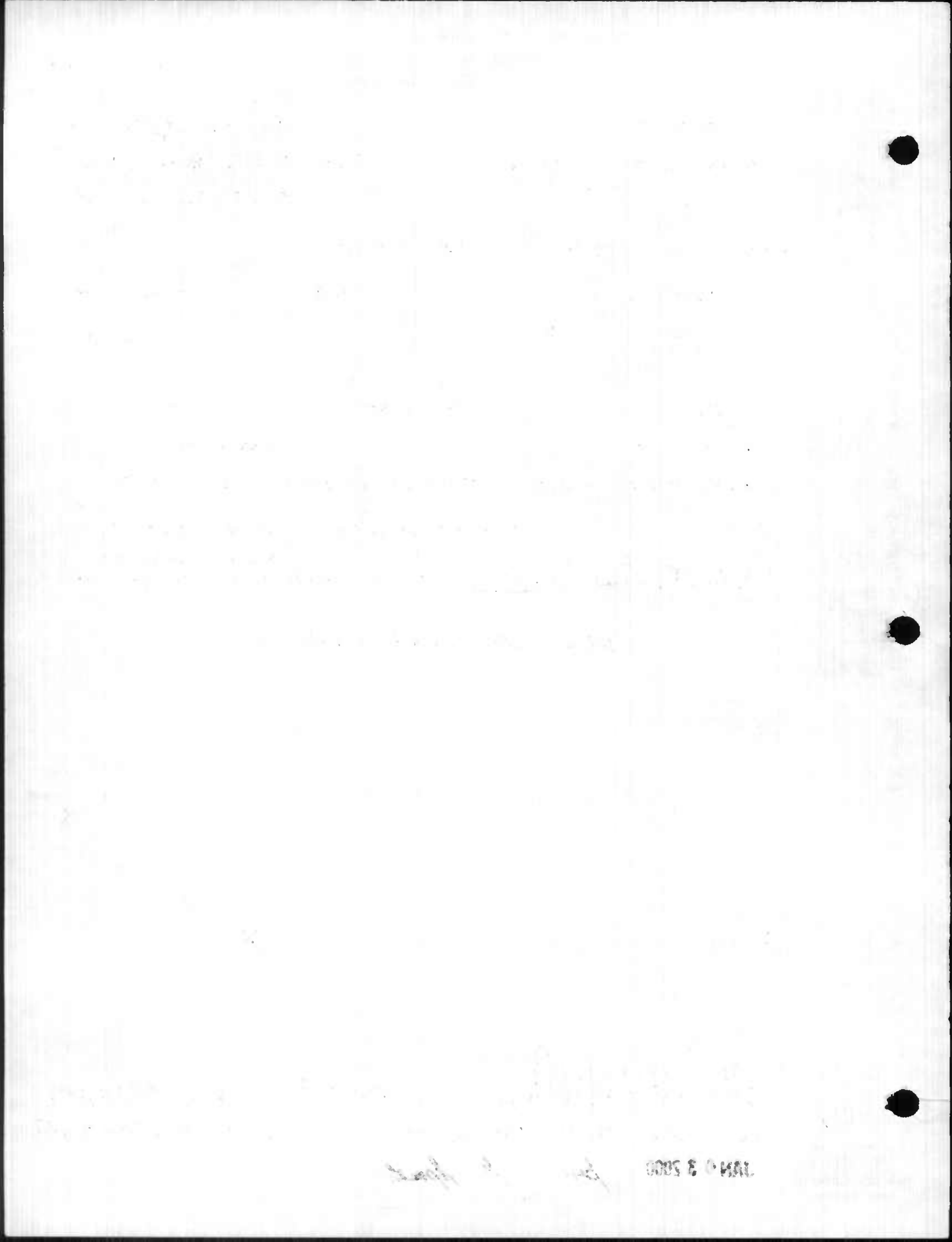
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(14)

State
Registrar



0005 E O HALL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42712

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Frank L. Harrison

2. Date of Death

Month
12Day
28Year
1999

3. Time of Death

9 30 pm

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

213-16-2612

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)

5/14/17

9. Birthplace (State or Foreign Country)

Muirkirk, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7808 Muirkirk Road

10f. Zip Code

20705

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 43-'45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Laboratory Aid

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Edward Gross

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Harrison

19a. Informant's Name/Relationship (Type, Print)

Lajoele A. Smalls/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14933 Belle Ami Dr., Laurel, Md. 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Nat'l. Mem. Park

Date

1/4/00

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

Mary M. Pratt

22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.

4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Acute Myocardial Infarction

1 day

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

Congestive Heart Failure

c.

Due to (or as a consequence of):

Hypertension

d.

Due to (or as a consequence of):

Diabetes Mellitus

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal insufficiency
Major depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Adel N. Mikhail

29c. License number

D13659

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ADEL N. MIKHAIL

3450 Fort Meade Rd.

Laurel, Md. 20794

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

0005 8 0111

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42713

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Hamlin				2. Date of Death Month Day Year December 30 1999				3. Time of Death 10:30 AM						
	4a. Facility Name (If not institution, give street and number) NORTH ARUNDEL HOSPITAL				4b. City, Town, or Location of Death GLEN BURNIE				4c. County of Death ANNE ARUNDEL						
Funeral Director	5. Social Security Number 578-18-2654		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 01-26-12		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent														
10a. State D. C.		10b. County		10c. City, Town or Location Washington						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1400 Fairmont St., N. W.						10f. Zip Code 20009				10g. Citizen of What Country? U. S. A.					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HouseKeeping				16b. Kind of Business/Industry Self-Employed					
17. Father's Name (First, Middle, Last) Unknown						18. Mother's Name (First, Middle, Maiden Surname) Ada Bell									
19a. Informant's Name/Relationship (Type, Print) Ann V. Haynes Daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 Spaulding Ave., Suitland, Md. 20746									
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico National				Date 1-7-00		20c. Location - City or Town, State Triangle, Va.					
21. Signature of Funeral Service Licensee Wanda C. Bacon C						22. Name and Address of Facility W. H. BACON FUNERAL HOME, INC. 3447 14th St., N.W. Washington, D. C. 20010									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier [Signature]						29c. License number D43977				29d. Date signed (Month, Day, Year) December 30 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anita D. [Signature] 301 Hospital Ave, Glen Burnie, MD 21061.															
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature [Signature]											

ORIGINAL

0005 8 11 HAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42714

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sarah Frances Hammill				2. Date of Death Month Day Year December 30, 1999				3. Time of Death 9:35 am		
	4a. Facility Name (If not institution, give street and number) Crofton Convalescent & Rehabilitation Center Crofton				4b. City, Town, or Location of Death Crofton				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 578-18-0419		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) April 14, 1915		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent 10a. State Maryland				10b. County Prince George's		10c. City, Town or Location Hyattsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number 6700 Belcrest Road - Apt. #418				10f. Zip Code 20782		10g. Citizen of What Country? U.S.A.				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Benjamin Franklin Aylor				18. Mother's Name (First, Middle, Maiden Surname) Laura Belle Harris						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Elsie P. Hynson - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9316 Calanda Street, Lanham, Maryland 20706						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Data 01/04/00		20c. Location - City or Town, State Brentwood, Maryland				
	21. Signature of Funeral Service Licensee Claudette J. Gasch				22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Adenocarcinoma to Brain Due to (or as a consequence of): b. Unknown Primary Adenocarcinoma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 6 months		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred			
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Howard K. Schutte Jr. MD		29c. License number 035848		29d. Date signed (Month, Day, Year) 12/30/99					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Howard K. Schutte Jr. 1438 Defense Hwy Gambrills, MD 21057											
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar

0005 2 0 HAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42715

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GREGORY GRIGGS HAWK

2. Date of Death

12 - 30 - 99

3. Time of Death

9:30 p.m.

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

220-42-4375

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6-16-46

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3707 Blackwater Road

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 6-22-64
6-21-68

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Supervisor - Metro

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

James W. Hawk

18. Mother's Name (First, Middle, Maiden Surname)

Maria Griggs

19a. Informant's Name/Relationship (Type, Print)

Roena V. Hawks / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3707 Blackwater Road, Clinton, MD 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland Veterans Cem.

Date

1-06-00

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Eric H. Strickland

22. Name and Address of Facility

Strickland Funeral Services, P.A.

6500 Allentown Rd, Camp Springs, MD 20748

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non Hodgkins Lymphoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.A. Meelu MD

29c. License number

D46246

29d. Date signed (Month, Day, Year)

December 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.A. MEELU MD

WALDORF MD 20603

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

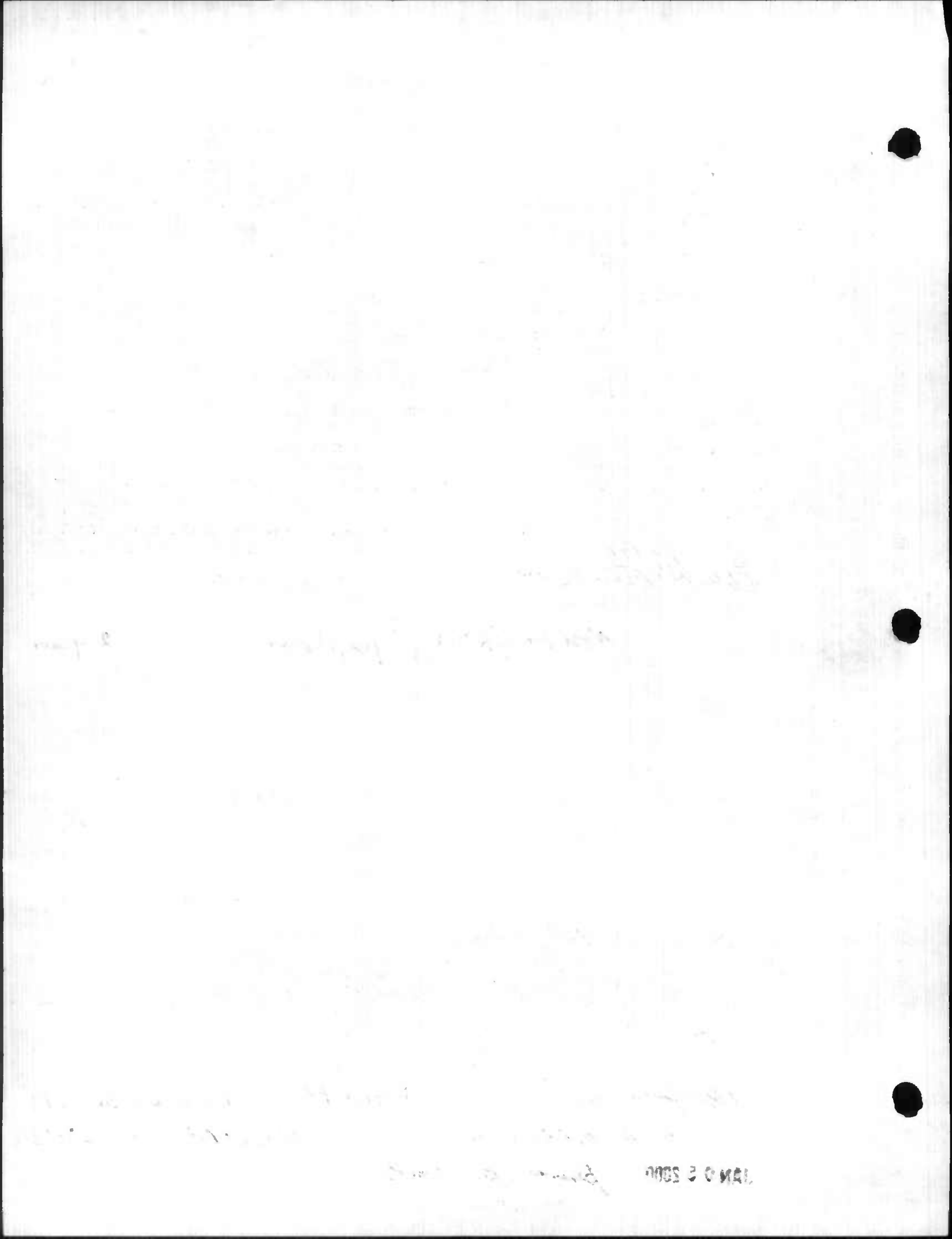
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42716

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED CARROLL HENDERSON, SR.

2. Date of Death

Month Day Year
DECEMBER 31, 1999

3. Time of Death

5:33 P.M.

4a. Facility Name (If not institution, give street and number)

MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death

CAMP SPRINGS

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

131-32-9738

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
November 26, 1942

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Suitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4413 Rena Road, #3

10f. Zip Code

20746

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates: 06/29/60 to 11/26/42

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Jessee Brice

18. Mother's Name (First, Middle, Maiden Surname)

Alice Henderson

19a. Informant's Name/Relationship (Type, Print)

Kathleen Henderson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4413 Rena Road, #3, Suitland, Maryland 20746

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

Date

01/10/2000

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

1 DAY

b. SEVERE CORONARY ARTERY DISEASE

Due to (or as a consequence of):

1 YEAR

c. DIABETES MELLITUS

Due to (or as a consequence of):

d. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TOBACCO ABUSE

CARDIO PULMONARY ARREST

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Percy Thompson

29c. License number

CA A060847

29d. Date signed (Month, Day, Year)

JANUARY 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEERACH P. PHERMSANGNAM, CAPT, USAF, MC ANDREWS AFB, MD 20762-6600

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

B. Spence

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

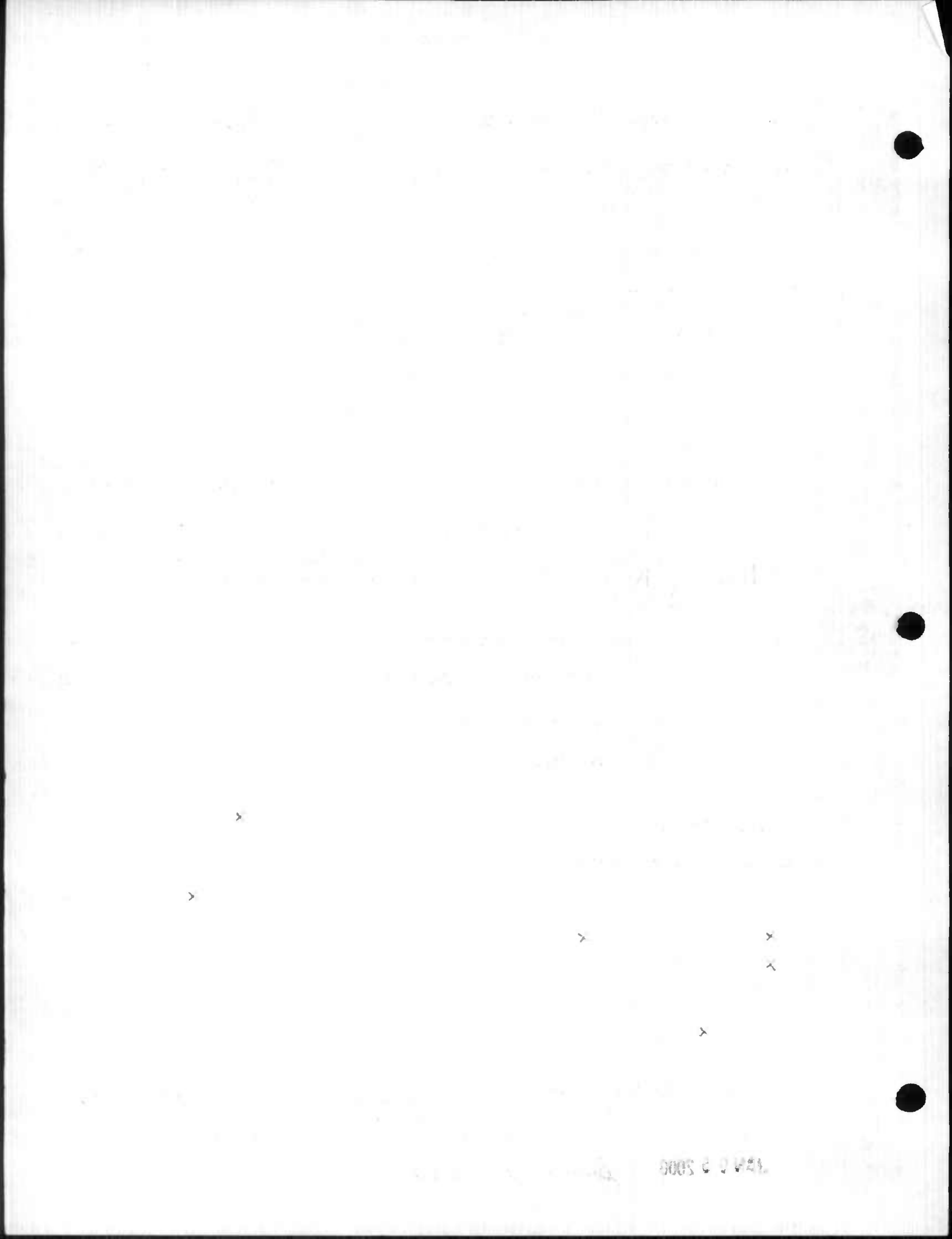
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42717**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gerald Keith Hall				2. Date of Death Month 12 Day 31 Year 99		3. Time of Death 5:37 PM	
	4a. Facility Name (If not institution, give street and number) Fort Washington Medical Center				4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 220-62-6120		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 09-07-54	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County Prince George's		10c. City, Town or Location Ft. Washington			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3405 Stonesboro Road				10f. Zip Code 20744		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Welder			16b. Kind of Business/Industry Metro	
17. Father's Name (First, Middle, Last) William Arthur Hall				18. Mother's Name (First, Middle, Maiden Surname) Marian Delores Makle				
19a. Informant's Name/Relationship (Type, Print) Jacqueline Hall / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3405 Stonesboro Rd., Ft. Washington, MD 20744				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery			20c. Location - City or Town, State 1/8/00 Clinton, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Felton Funeral Services P.O. Box 1351, Forestville, MD 20747				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): b. Nonobstructive hypertrophic cardiomyopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperthyroidism								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. Signature and title of certifier 
29c. License number D52176				29d. Date signed (Month, Day, Year) 1/5/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen McGibbon, MD, 5100 Auth Way, Suitland, MD 20746								
31. Date filed (Month, Day, Year) JAN 0 5 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

Handwritten signature or initials

1000 2 0 000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42718

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ERNESTINE HUNTER

2. Date of Death

December 31, 1999

3. Time of Death

0623 AM

4a. Facility Name (If not institution, give street and number)

WORTHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

TAKOMA PARK

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

577-40-8549

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Sept. 19, 1927

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

6428 North Capitol Street N.W.

10f. Zip Code

20012

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

File Clerk

16b. Kind of Business/Industry

Dept. of Navy

17. Father's Name (First, Middle, Last)

Edward T. Holmes

18. Mother's Name (First, Middle, Maiden Surname)

Annie Harrison

19a. Informant's Name/Relationship (Type, Print)

Deborah Lee - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6428 North Capitol St., N.W. Washington DC 20012

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

1-10-00

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Julia P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Washington DC 20011

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOMYOPATHY

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ECG-STATES RURAL DISEASE

Due to (or as a consequence of):

c. HYPERTENSION

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certify (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

m. (ONE)

29c. License number

015236

29d. Date signed (Month, Day, Year)

October 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL H. MORGAN, MD - (ONE) 1115 Rockville Pike, Rockville, MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JAN 2 5 00 PM '68

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42719**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alvin A. Hall				2. Date of Death Month Day Year December 30th 1999		3. Time of Death 1248 Am	
	4a. Facility Name (If not institution, give street and number) Sinai Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 230-77-2898		6. Sex 10 M 20 F		7. Age (In yrs. Last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 30, 1945	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Owings	
10d. Inside City Limits 10 Yes 20 No		10e. Street and Number 5840 John Chapel Road		10f. Zip Code 20736		10g. Citizen of What Country? USA		
11. Marital Status 10 Never Married 20 Married 30 Widowed 40 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 20 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10 Yes 20 No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber		16b. Kind of Business/Industry Self Employed				
17. Father's Name (First, Middle, Last) Frank Hall				18. Mother's Name (First, Middle, Maiden Surname) Annie L. Holland				
19a. Informant's Name/Relationship (Type, Print) Vernita Jones/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Race St. Fairmont, West Virginia 26554				
20a. Method of Disposition 10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Hope UM Church Cem.		Date 1/5/00		20c. Location - City or Town, State Sunderland, MD		
21. Signature of Funeral Service Licensee Blayne G. Sewell				22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Sepsis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 10 Yes 20 No 30 Probably 40 Unknown								
24a. Was an autopsy performed? 10 Yes 20 No								
24b. Were autopsy findings available prior to completion of cause of death? 10 Yes 20 No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIOMYOPATHY								
25. Was case referred to medical examiner? 10 Yes 20 No		26. Place of Death (Check only one) Hospital: 10 Inpatient 20 ER/Outpatient 30 DOA Other: 40 Nursing Home 50 Residence 60 Other (Specify)						
27. Manner of Death 10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending investigation 60 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 10 Yes 20 No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Dr. Michael M.D.				29c. License number RES 000		29d. Date signed (Month, Day, Year) December 30th 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Meister / Sinai Hospital								
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature Benita B. Sparks						

To Be Completed by Funeral Director

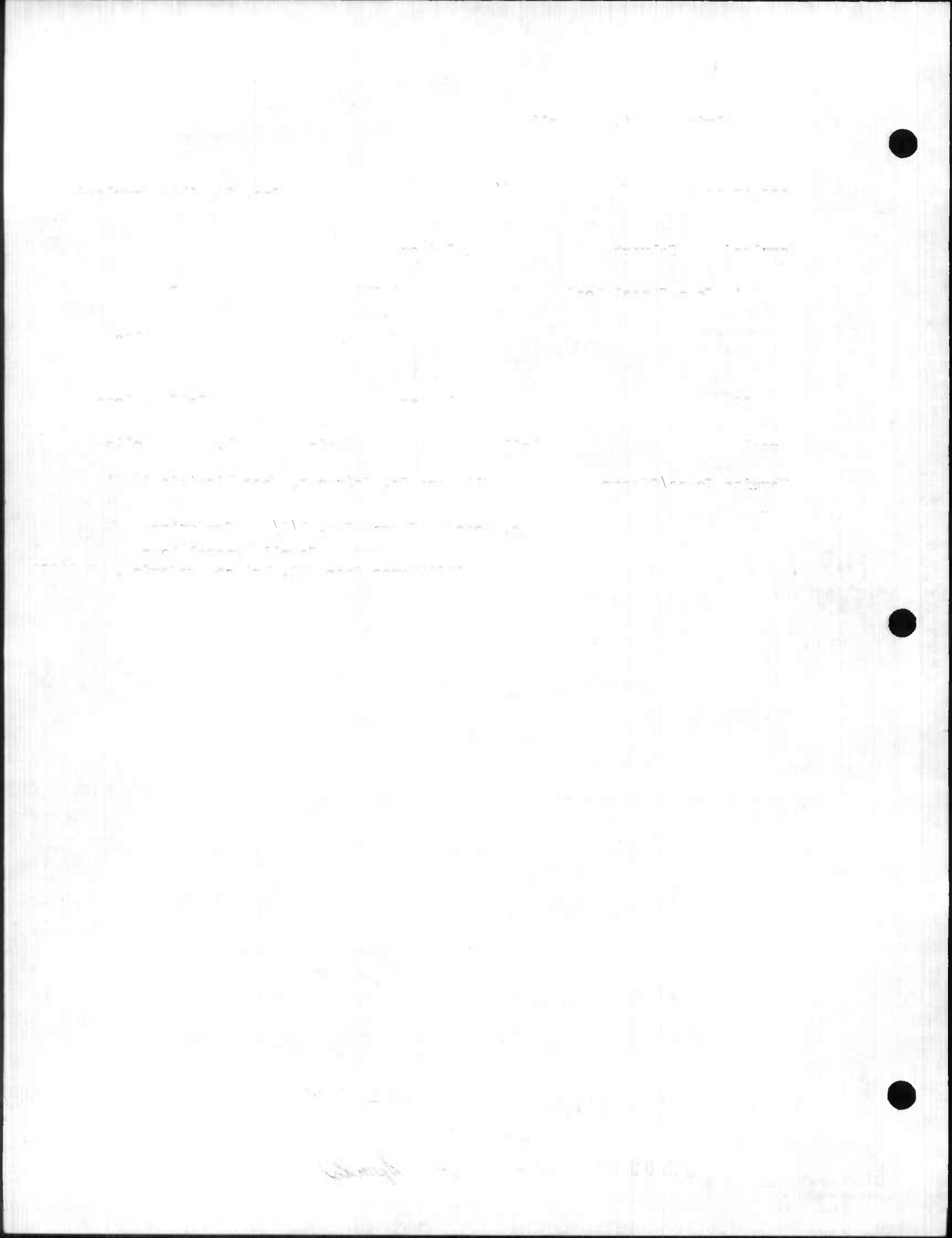
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42720

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

EDWARD (NMN) JREIGE

2. Date of Death
Month Day Year
DECEMBER 29, 19993. Time of Death
10:14 AM

4a. Facility Name (If not institution, give street and number)

National Institute of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

132-66-8981

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth
(Month, Day, Year)

Dec. 14, 1967

9. Birthplace (State or Foreign Country)

Melbourne, Australia

Usual Residence of Decedent

10a. State

New York

10b. County

Erie

10c. City, Town or Location

Cheektowaga

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

83 West Cavalier

10f. Zip Code

14227

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Anthony Jreige

18. Mother's Name (First, Middle, Maiden Surname)

Madeleine Shady

19a. Informant's Name/Relationship (Type, Print)

Anthony Jreige - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

83 West Cavalier, Cheektowaga, NY 14227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

Date

1-6-00

20c. Location - City or Town, State

Lackawanna, New York

21. Signature of Funeral Service Licensee

Julia P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Washington DC 20011

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NONSPECIFIC INTERSTITIAL LUNG DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MONTHS.

b. VENTILATOR ASSOCIATED PNEUMONIA

Due to (or as a consequence of):

WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIPODYSTROPHY - INSULIN RESISTANCE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury
(Month, Day Year)

N/A.

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory J. Macchio MD

29c. License number (MD)

D 0052707

29d. Date signed (Month, Day, Year)

12/29/1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory J. Macchio MD 9000 ROCKVILLE PIKE, BETHESDA, MD 20892

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

Beverly B. Spauld

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or initials.

0005 P. 0. HAL.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42721

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Clifton William Johnson

2. Date of Death

Month Day Year
DECEMBER 31, 1999

3. Time of Death

1:34 PM

4a. Facility Name (If not institution, give street and number)

Doctor's Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

214-30-9394

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Jan. 11, 1935

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Prince Georges

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3605 Clairton Drive

10f. Zip Code

20721

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☒ Yes ☐ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

News Cameraman

16b. Kind of Business/Industry

CBS

17. Father's Name (First, Middle, Last)

George Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Alice Dashield

19a. Informant's Name/Relationship (Type, Print)

Janett Johnson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3605 Clairton Drive
Mitchellville, MD. 20721

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crossroads Cem.

Date

1/7/00

20c. Location - City or Town, State

Crossroads, MD.

21. Signature of Funeral Service Licensee

Hodges & Edwards F.H.

22. Name and Address of Facility

3910 Silver Hill RD. Suitland, MD. 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
stroke, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. Acute Myocardial Infarction

1/2 hour

Due to (or as a consequence of):

b. Coronary Artery Disease

5 years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy

performed?

☐ Yes ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

☐ Yes ☒ No

25. Was case referred to medical

examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☒ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending
Investigation
☐ Accident ☐ Could not be
determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)☒Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Jay Zwally II

29c. License number

D42684

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Jay Zwally, 575 Main Street, Suite 253 Laurel, Md. 20707

31. Date filed (Month, Day, Year)

JAN 0 5 2000

32. Registrar's Signature

Shirley B. Sparks

State
Registrar

Handwritten text, possibly a signature or date, located at the bottom center of the page.

0005 2 1971

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

ELVIRE

JACKSON

2. Date of Death

Month Day Year
December 24, 1999

3. Time of Death

9:30AM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

5. Social Security Number

578-24-5030

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/21/10

9. Birthplace (State or Foreign)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

DC

10b. County

N/A

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

429 QUACKENBOS ST NW

10f. Zip Code

20011

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

US ARMY

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

BLACK

Specify:

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

4 YEARS

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Unknown

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

ASHWORD D. HOLDER

18. Mother's Name (First, Middle, Maiden Surname)

AGNES ADA DAVIS

19a. Informant's Name/Relationship (Type, Print)

LANCELOT A. HOLDER (NEPHEW)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS 10A, B, C, D, E, & F

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Quantico Nat. Cem.

Date

1/11/00 Quantico Va.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

#CG0273

22. Name and Address of Facility

JOHN T. RHINES CO., INC.

3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease Exacerbation

Due to (or as a consequence of):

Unknown

b. Pneumonia

Due to (or as a consequence of):

Unknown

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samir Kheiri

29c. License number

D0052064

29d. Date signed (Month, Day, Year)

December 24, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMIR KHEIRI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

B. Sparks

State

Registrar

NAME KNOWN TO PHYSICIAN: JACKSON, ELVIRE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint handwritten signature]

Carroll County, wjl
Amended Item 1, per Phy.
Amended Items 12, 17, 19a, per F.D. 1/10/2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42723

Amended Items 12, 17, 19a, per F.D. 1/10/2000 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JUSTIN ROBERTSON LAWSON, JR. Justin Robertson Lawson				2. Date of Death Month December Day 29 , Year 1999		3. Time of Death 9:50pm	
	4a. Facility Name (If not institution, give street and number) 510 Piney Run Court				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 217-40-1214		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 27, 1943	
	9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent								
10a. State MD		10b. County Carroll		10c. City, Town or Location Sykesville			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 510 Piney Run Court				10f. Zip Code 21784		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1961-1968		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor of Ad Operations			16b. Kind of Business/Industry Newspaper	
17. Father's Name (First, Middle, Last) Justin Robertson Lawson, Sr. Justin Robertson, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna Marie Breivogel				
19a. Informant's Name/Relationship (Type, Print) Mrs. Mary A. Lawson (Wife) Mrs. Mary D Lawson (wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Piney Run Court, Sykesville, MD 21784				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Springfield Cemetery		Date 1/4/2000		20c. Location - City or Town, State Sykesville, MD
21. Signature of Funeral Service Licensee Brian R. Haight				22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (PO Box 195) Sykesville, MD 21784 (410)-795-1400				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lymphoma							Approximate Interval Between Onset and Death 8 months
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier St. Anthony Riley, MD				29c. License number D25205		29d. Date signed (Month, Day, Year) December 31, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.A.Riley G. BMC 6701 N. Charles St. Balto. md 21208								
State Registrar	31. Date filed (Month, Day, Year) JAN 05 2000				32. Registrar's Signature B. Sparks			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

JAN 18 2002

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42724

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMILY LANDA				2. Date of Death Month Day Year DEC. 29, 1999				3. Time of Death 1:30 AM	
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE				4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 117-03-1905		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 9, 1909		9. Birthplace (State or Foreign Country) NEW YORK	
	Usual Residence of Decedent									
10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 9701- VEIRS DRIVE				10f. Zip Code 20850				10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SCHOOL TEACHER				16b. Kind of Business/Industry EDUCATION		
17. Father's Name (First, Middle, Last) MYER E. SCHWARTZ				18. Mother's Name (First, Middle, Maiden Surname) EVA RABINOWITZ						
19a. Informant's Name/Relationship (Type, Print) DAN LANDA-BROTHER IN LAW				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4604- BUTTERWORTH PL., N.W., WASH., DC						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY-12/31 ALEXANDRIA, VA.				20c. Location - City or Town, State		
21. Signature of Funeral Service licensee <i>W. H. Young</i>				22. Name and Address of Facility HYSONG CO., INC. FUNERAL HOME 1300- N STREET, NW, WASH., DC						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SHOCK Due to (or as a consequence of): RESPIRATORY FAILURE Due to (or as a consequence of): CARDIOMYOPATHY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4 DAYS 5 DAYS YEARS		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE PASSIN PNEUMONIA								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Charles W. Karesch</i>				29c. License number D 21726		
				29d. Date signed (Month, Day, Year) DEC. 29, 1999						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. CHARLES W. KARESH - 9701- VEIRS DR., ROCKVILLE, MD. 20850										
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature <i>Barbara B. Apal</i>						

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42725

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Deda Langley				2. Date of Death Month December Day 31 , Year 1999		3. Time of Death 8:30 PM	
	4e. Facility Name (If not institution, give street and number) Pineview Nursing Home				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-66-8227		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 101 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 6, 1898	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Suitland		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3412 Aberdeen Street				10f. Zip Code 20746		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th Collage (1-4or 5+) N/A				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Alexander M. Lyon				18. Mother's Name (First, Middle, Maiden Surname) Roberta Ching				
19e. Informant's Name/Relationship (Type, Print) John E. Langley (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3412 Aberdeen Street Suitland, Maryland 20746				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		Date Jan. 5, 2000		20c. Location - City or Town, State Suitland, Maryland		
21. Signature of Funeral Service Licensee MO1095				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Acute Pulmonary edema Due to (or as a consequence of): b. chronic Congestive heart failure Due to (or as a consequence of): c. chronic Pulmonary obstructive disease Due to (or as a consequence of): d. _____								Approximate Interval Between Onset and Death 48 hours >10 years. >10 years.
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Alain G. Champaloux MD						
		29c. License number D42049		29d. Date signed (Month, Day, Year) January 3, 2000				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Alain G. CHAMPALOUX MD. Upper Marlboro Md 20772								
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature 						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

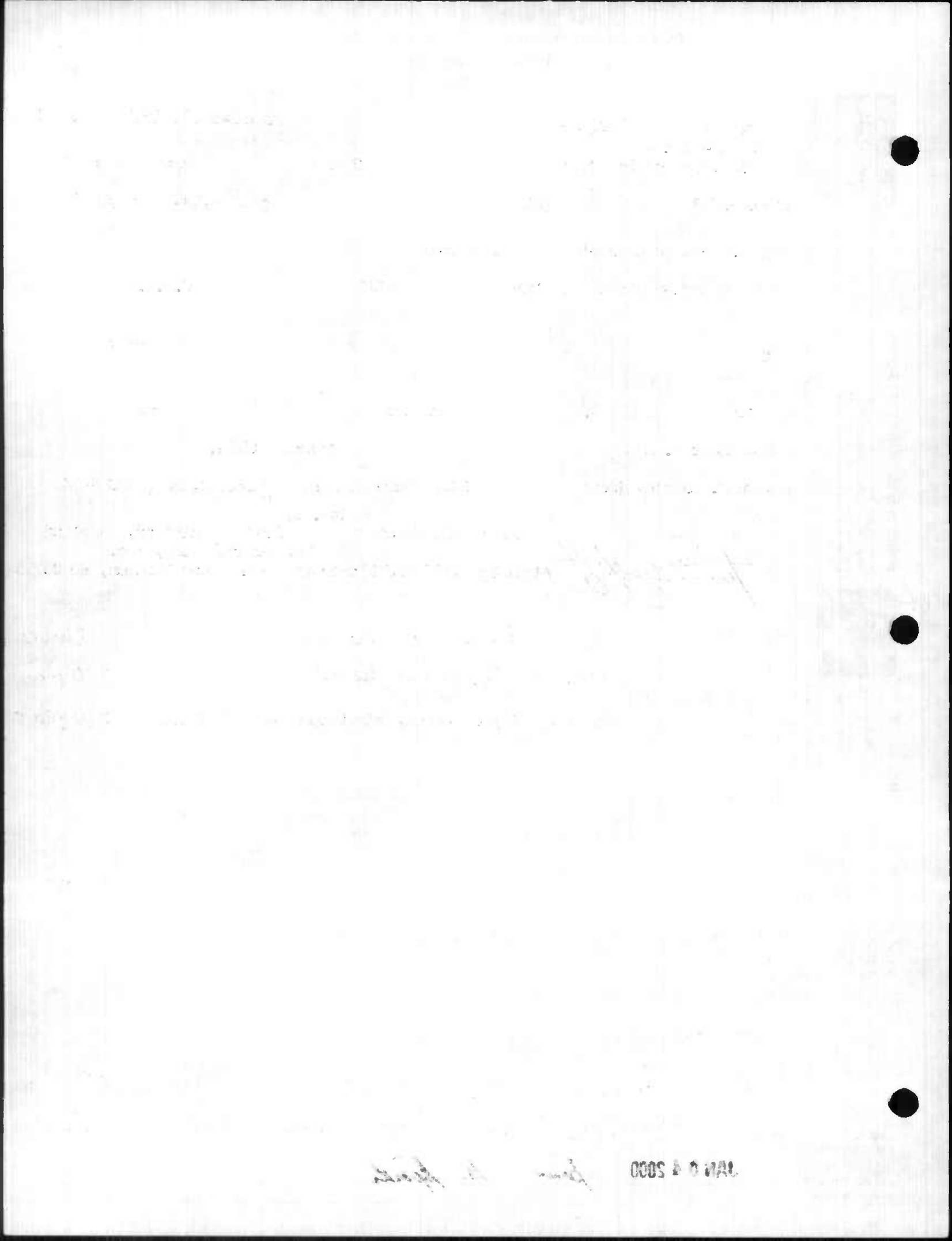
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42726

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Susanne LeRoy

2. Date of Death

Month Day Year
December 29, 1999

3. Time of Death

2:00 a.m.

4a. Facility Name (If not institution, give street and number)

6515 8th Avenue

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

216-18-0603

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Feb. 6, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6515 8th Avenue

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Prince George's County
Liquor Board

17. Father's Name (First, Middle, Last)

Phillip Ryan

18. Mother's Name (First, Middle, Maiden Surname)

(Unavailable)

19a. Informant's Name/Relationship (Type, Print)

Cyril F. LeRoy - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6515 8th Avenue, Adelphi, Maryland 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

12/31/99

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Clandette J. Gasch

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Advanced Chronic Obstructive Pulmonary Disease

4 Years

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cor Pulmonale

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

A. A. Chacko

29c. License number

D20129

29d. Date signed (Month, Day, Year)

December 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A.A. Chacko, M.D. 7610 Carroll Avenue #390, Takoma Park, Maryland 20912-6315

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

Beverly B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42727

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Faye C. Lundy				2. Date of Death Month Day Year December 31, 1999				3. Time of Death 12:25PM	
	4a. Facility Name (If not institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 578-60-8331		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 18, 1945		9. Birthplace (State or Foreign Country) Wash., D.C.	
	Usual Residence of Decedent									
10a. State District of Columbia		10b. County Washington		10c. City, Town or Location Washington				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 3668 Hayes St., N.E. #102				10f. Zip Code 20019		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Program Assistant				16b. Kind of Business/Industry Government		
17. Father's Name (First, Middle, Last) Russell Lundy, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Dorothy McDaniel						
19a. Informant's Name/Relationship (Type, Print) Lewis Joyner - Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4300 - 74th Ave., Landover Hills, MD 20784						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 1/7/2000		20c. Location - City or Town, State Brentwood, MD			
21. Signature of Funeral Service Licensee John T. Stewart, III				22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arrhythmia Due to (or as a consequence of): b. Seizure disorder Due to (or as a consequence of): c. diabetes Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
							24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Coerver				29c. License number D54550				29d. Date signed (Month, Day, Year) 12/31/99		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Christine Coerver, M.D. - 3001 Hospital Dr., Cheverly, MD 20785										
31. Date filed (Month, Day, Year) JAN 05 2000		32. Registrar's Signature Beverly B. Spack								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42728

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence E. Mockabee				2. Date of Death Month Day Year December 29, 1999		3. Time of Death 5:03AM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital Center				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 579-14-2563	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	8. Date of Birth (Month, Day, Year) Feb. 22, 1919	9. Birthplace (State or Foreign Country) Washington, D.C.			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George		10c. City, Town or Location Forestville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 7420 Marlboro Pike		10f. Zip Code 20747		10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher		16b. Kind of Business/Industry N.Y. School System			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Henry C. Mockabee				18. Mother's Name (First, Middle, Maiden Surname) Pearl E. Posey			
	19a. Informant's Name/Relationship (Type, Print) Maggie DeGeorge/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 628 Bethany Loop Bethany Beach, DE. 19930			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, VA.		20d. Date 12/31/99	
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>		22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>RESPIRATORY FAILURE</u> Due to (or as a consequence of): b. <u>PNEUMONIA</u> Due to (or as a consequence of): c. <u>ASPIRATION PNEUMONIA</u> Due to (or as a consequence of): d. <u>SEPTIC SHOCK</u>							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ALZHEIMER'S DEMENTIA</u>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Henri De la Baume</i>		29c. License number D34498		29d. Date signed (Month, Day, Year) Dec 29, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HENRI De LA BAUME M.D. Clinton, MD 20735							
State Registrar	31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature <i>B. Sparks</i>					

0005 8 0 MAR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42729

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

THERESA

M.

MALCZYNSKI

2. Date of Death

Month

Day

Year

December 27 1999

3. Time of Death

2:45pm

Funeral
Director

4a. Facility Name (If not institution, give street and number)

DOCTOR'S COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGES

5. Social Security Number

723-18-1408

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 18, 1925

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

BOWIE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12205 MARNE LANE

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGEMENT ANALYST

16b. Kind of Business/Industry

DEPT. OF DEFENSE

17. Father's Name (First, Middle, Last)

ANTHONY

COSTANTINO

18. Mother's Name (First, Middle, Maiden Summa)

ROSE

MARCHETTI

19a. Informant's Name/Relationship (Type, Print)

GERALDINE E. TIMON/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS 10 e

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cemetery

Date

Jan. 3, 2000

20c. Location - City or Town, State

Brentwood, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc 16000

Annapolis Rd., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction / Congestive Heart Failure

Due to (or as a consequence of):

Hours/daysc. Diabetes

Due to (or as a consequence of):

d. Obesity

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HypertensionObesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

52119

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sridhar Chattrathi 8100 Goodluck Road Suite 302 Lanham Md 20706

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Physician
/Medical
ExaminerTheresa Margaret Malczynski
Baltimore, Maryland 21215-0020

[Faint handwritten text]

0005 6 0 MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42730**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **Alfred John Mozier** 2. Date of Death Month **DECEMBER** Day **30** Year **1999** 3. Time of Death **1800**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **6417 MORTON PLACE** 4b. City, Town, or Location of Death **TEMPLE HILLS** 4c. County of Death **PRINCE GEORGES**
 5. Social Security Number **196-24-8985** 6. Sex **XX** M ☐ F ☒ 7. Age (In yrs. last birthday) **67** Yrs. 8. Date of Birth (Month, Day, Year) **MARCH 10, 1932** 9. Birthplace (State or Foreign Country) **NEW JERSEY**

To Be Completed by Funeral Director

Usual Residence of Decedent
 10a. State **Maryland** 10b. County **Prince George's** 10c. City, Town or Location **Temple Hills** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **6417 Morton Place** 10f. Zip Code **20748** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **12** Collage (1-4 or 5+) **5+** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Sergeant Major Ret.** 16b. Kind of Business/Industry **United States Army**

17. Father's Name (First, Middle, Last) **Alfred John Mozier** 18. Mother's Name (First, Middle, Maiden Surname) **Florence Warden**

19a. Informant's Name/Relationship (Type, Print) **Sue Ying Mozier (Wife)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **6417 Morton Place Temple Hills, Maryland 20748**

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Lee Crematory** Date **Jan. 6, 2000** 20c. Location - City or Town, State **Clinton, Maryland**

21. Signature of Funeral Service Licensee 22. Name and Address of Facility **Lee Funeral Home, Inc.**
6633 Old Alexandria Ferry Road Clinton, Maryland 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **CANCER OF LUNG** 23b. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) **CANCER OF LUNG**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? ☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? **N/A**

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29c. License number **033954** 29d. Date signed (Month, Day, Year) **DECEMBER 31, 1999**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785**

31. Date filed (Month, Day, Year) **JAN 04 2000** 32. Registrar's Signature **[Signature]**

State
Registrar

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature or scribble

0005 0 1441

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42731

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John James May				2. Date of Death Month Day Year DECEMBER 30, 1999		3. Time of Death 1725	
	4a. Facility Name (If not institution, give street and number) 11912 ELMWOOD DRIVE				4b. City, Town, or Location of Death BRANDYWINE		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 578-48-2972		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth Month Day Year NOV. 26, 1937	
	9. Birthplace (State or Foreign) Washington DC		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Brandywine	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 11912 Elmwood Drive		10f. Zip Code 20613		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Budget Analyst		16b. Kind of Business/Industry Federal Government				
17. Father's Name (First, Middle, Last) James John May				18. Mother's Name (First, Middle, Maiden Surname) Mildred Fitzhugh				
19a. Informant's Name/Relationship (Type, Print) Angelina May (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11912 Elmwood Drive Brandywine, Maryland 20613				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland		20d. Date Jan. 4, 2000		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D33954		29d. Date signed (Month, Day, Year) DECEMBER 31, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785								
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten signature or initials

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

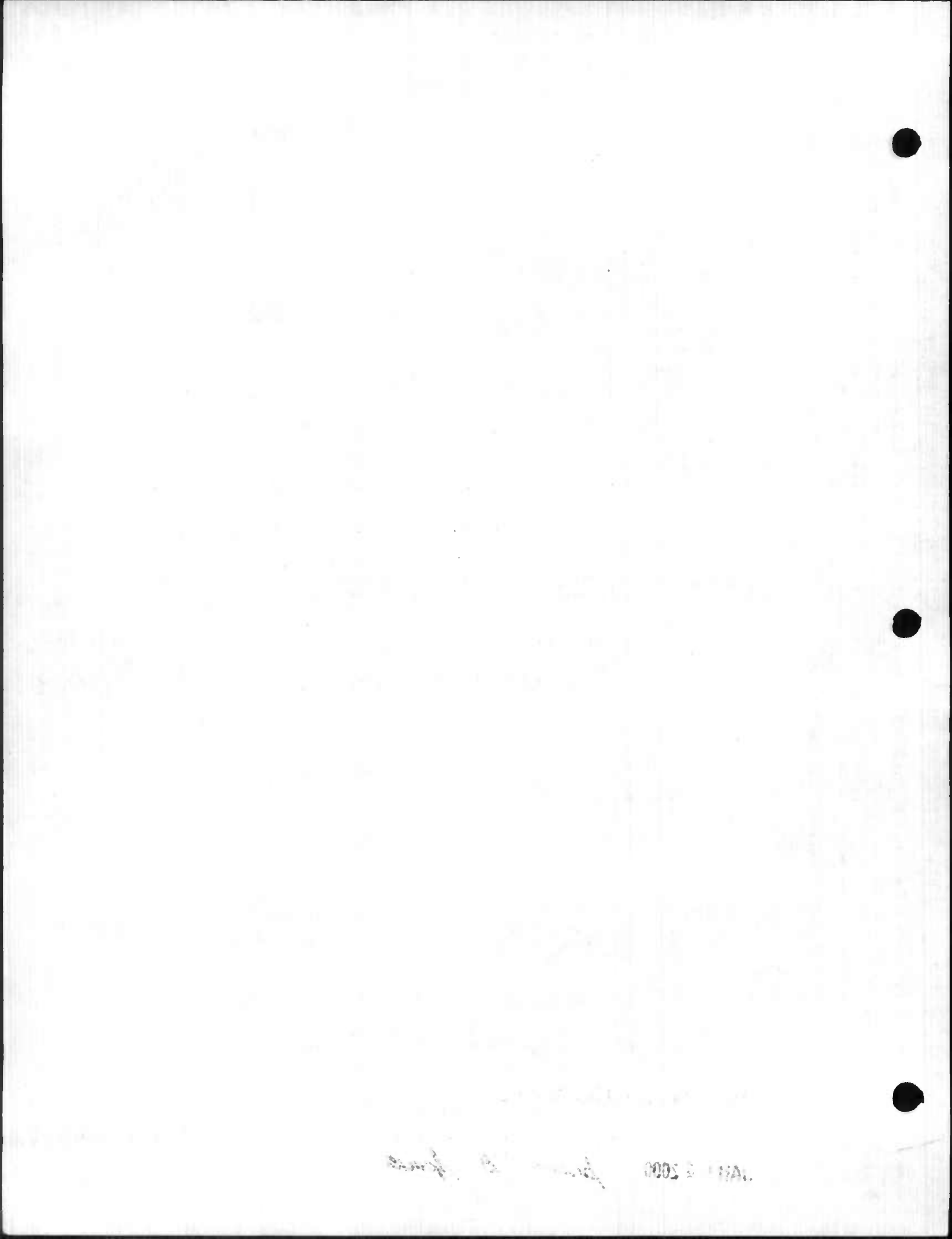
State of Maryland / Department of Health and Mental Hygiene 99 42732

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John William McDevitt				2. Date of Death Month Day Year December 30 1999		3. Time of Death 08:16 AM									
	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's									
Funeral Director	5. Social Security Number 577-50-1410	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60	8. Date of Birth (Month, Day, Year) June 13, 1939	9. Birthplace (State or Foreign Country) Washington, D.C.											
	Usual Residence of Decedent															
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Riverdale		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number 5908 Cleveland Avenue				10f. Zip Code 20737		10g. Citizen of What Country? U.S.A.										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Town of Riverdale Public Works										
17. Father's Name (First, Middle, Last) Royce McDevitt				18. Mother's Name (First, Middle, Maiden Surname) Gladys Blacker												
19a. Informant's Name/Relationship (Type, Print) Royce McDevitt - Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5908 Cleveland Avenue, Riverdale, MD 20737												
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. Location - City or Town, State Brentwood, Maryland		20d. Date 1/5/00										
21. Signature of Funeral Service Licensee Claudette J. DASH				22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. RESPIRATORY FAILURE</td> <td>24 HRS</td> </tr> <tr> <td>b. MAIGNANT LYMPHOMA</td> <td>10 YRS</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RESPIRATORY FAILURE	24 HRS	b. MAIGNANT LYMPHOMA	10 YRS	c.		d.	
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. RESPIRATORY FAILURE	24 HRS														
	b. MAIGNANT LYMPHOMA	10 YRS														
	c.															
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred												
28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. Signature and title of certifier Marian D. Welitz				29c. License number D23743		29d. Date signed (Month, Day, Year) 1-2-00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN D. WELTZ, MD 7525 GREENWAY CTR DR, GREENBELT, MD 20770																
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature B. Spauld												

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42733

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EVERETT D. MASTERSON					2. Date of Death Month Day Year December 29, 1999		3. Time of Death 12:27 PM		
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital					4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-22-1369		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 24, 1921		9. Birthplace (State or Foreign Country) Washington DC	
	Usual Residence of Decedent					10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10a. State Maryland		10b. County Montgomery		10e. Street and Number 7051 Carroll Avenue, #203		10f. Zip Code 20912-4412		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry General Services Admin.			
17. Father's Name (First, Middle, Last) Julius Masterson					18. Mother's Name (First, Middle, Maiden Surname) Rosa Davis					
19a. Informant's Name/Relationship (Type, Print) Toni Farmer - Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 Parade St., Erie, PA. 16503					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery			20c. Location - City or Town, State 1-4-00 Brentwood, Maryland				
21. Signature of Funeral Service Licensee Julia P. Marshall					22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Urog Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia Congestive Heart Failure							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier			29c. License number A42749		29d. Date signed (Month, Day, Year) 12/30/99		
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Raymond Nwadiuko, M.D. 9831 Greenbelt Road, Lanham, MD 20706										
31. Date filed (Month, Day, Year) JAN 04 2000			32. Registrar's Signature B. Sparks							

To Be Completed by Funeral Director

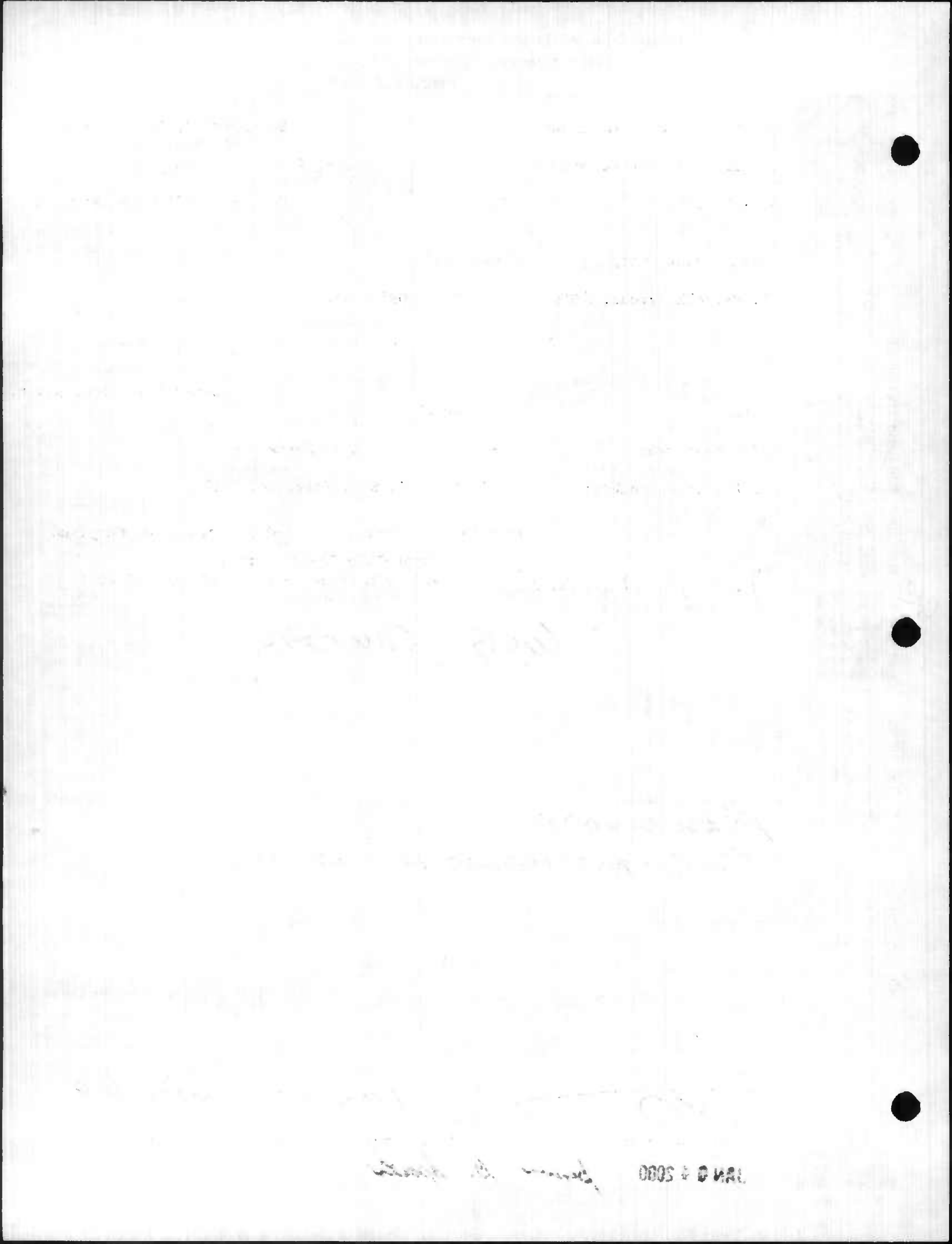
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42734

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DENNIS (NMN) MCBRIDE				2. Date of Death Month Day Year DECEMBER 28, 1999		3. Time of Death 6:08 PM	
	4a. Facility Name (If not institution, give street and number) National Institute of Health				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 221-34-6231		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) February 8, 1949	
	9. Birthplace (State or Foreign Country) Delaware		10a. State Delaware		10b. County New Castle		10c. City, Town or Location Wilmington	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 702 W 22nd Street		10f. Zip Code 19802		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> 5 +		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney		16b. Kind of Business/Industry Private Practice			
	17. Father's Name (First, Middle, Last) George J. McBride				18. Mother's Name (First, Middle, Maiden Surname) Rita Dennis			
	19a. Informant's Name/Relationship (Type, Print) Patricia McBride - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 702 W 22nd Street, Wilmington, Delaware 19802			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) All Saints		20c. Date 1-3-00		20d. Location - City or Town, State Newark, Delaware	
	21. Signature of Funeral Service Licensee Julia P. Marshall				22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011			
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. sepsis Bone Marrow Transplant Melanoma							
	Approximate Interval Between Onset and Death 1 day 2 months 23 years							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. coronary artery disease							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Robert K. Pelz MD				29c. License number 048114		29d. Date signed (Month, Day, Year) December 28, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert K. Pelz MD 9000 ROCKVILLE PIKE, BETHESDA, MD 20892								
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature Brown B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

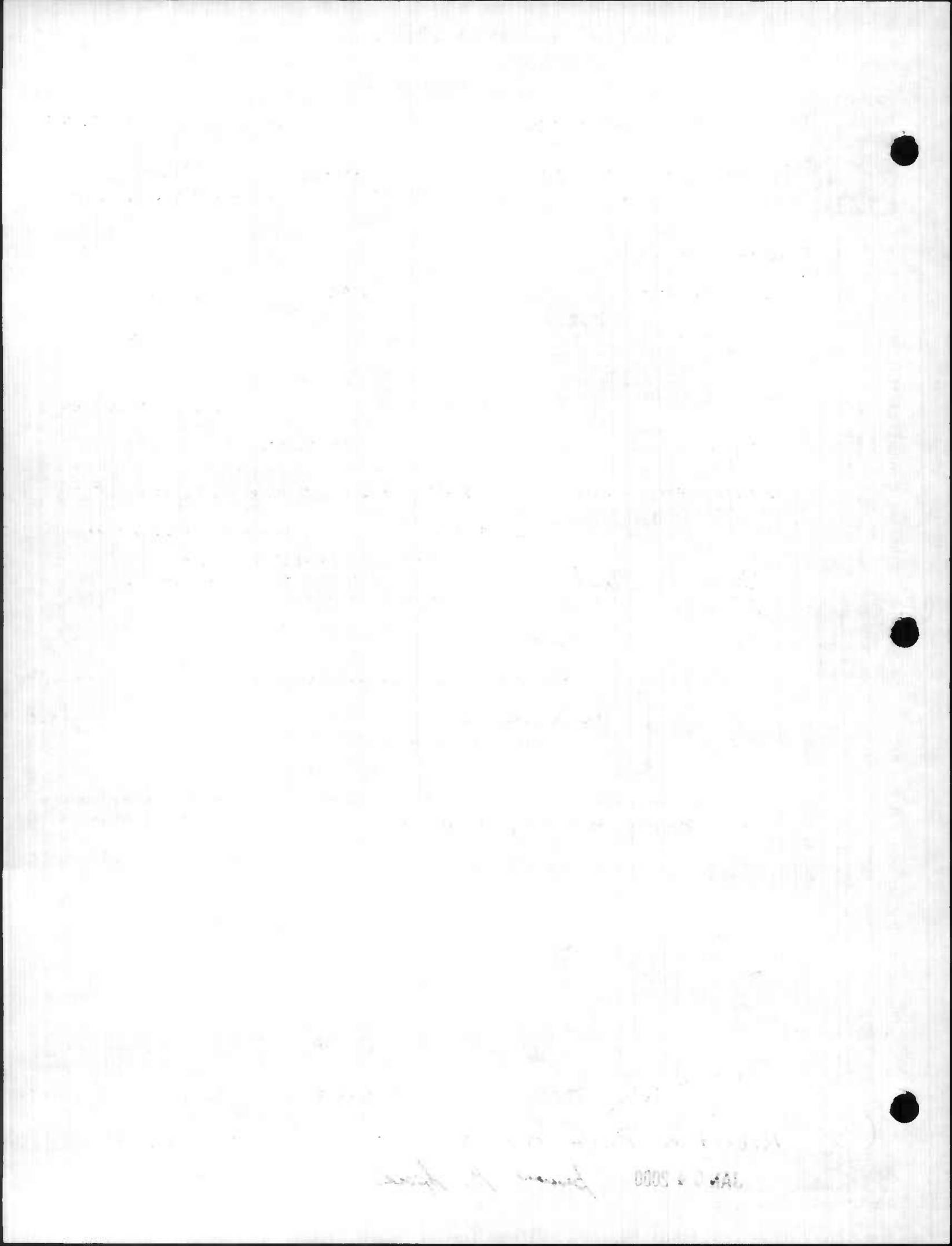
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State
Registrar



Handwritten signature

JAN 2 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42735

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE

NEUBEN

2. Date of Death

Month Day Year
DECEMBER 30, 1999

3. Time of Death

11:10 AM

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

FREDERICK

Funeral
Director

5. Social Security Number

227-28-0768

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

6. Date of Birth

(Month, Day, Year)
FEB 21, 1916

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

FREDERICK

10c. City, Town or Location

FREDERICK

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1001 CARROLL PARKWAY APT 406

10f. Zip Code

21701

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☐ Married
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

ROBERT HORNE

18. Mother's Name (First, Middle, Maiden Surname)

POLLIE SEXTON

19a. Informant's Name/Relationship (Type, Print)

JERRY DUBE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 CRAMER AVENUE, WALKERSVILLE MARYLAND 21793

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

1-5-2000

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

Shawn Buki

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME INC

3401 BLADENSBURG RD, BRENTWOOD MD 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOGENIC SHOCK

Due to (or as a consequence of):

b. Acute Mitral Regurgitation

Due to (or as a consequence of):

c. Complete Heart Block

Due to (or as a consequence of):

d. Acute Inferior wall Myocardial infarction

Approximate Interval Between Onset and Death

12 hrs

36 hrs

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No25. Was case referred to medical examiner?
☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Shawn Buki MD

29c. License number

D0054616

29d. Date signed (Month, Day, Year)

December 30 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAWN BUKI 310 W. 9th St Frederick Md 21701

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Handwritten text, possibly a signature or date, located in the center of the page.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42736
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Barbara Jean Price

2. Date of Death

Month

Day

Year

December 29 1999 6:05 AM

3. Time of Death

Funeral
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

578-90-8515

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 13, 1957

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

683 Frost Valley Lane

10f. Zip Code

21054

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Clary

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Blair

19a. Informant's Name/Relationship (Type, Print)

Christopher Price/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

683 Frost Valley Lane Gambrills, Md. 21054

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan

Crematory

Date

12-31-99

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

Shannon W. Beall
Shannon W. Beall M00798

22. Name and Address of Facility

Beall Funeral Home
6512 N.W. Crain Highway Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a.

ASPIRATION PNEUMONIA

Due to (or as a consequence of):

b.

HEPATIC FAILURE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier
(Check only one)1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Shannon W. Beall MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

December 29 1999

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

Gyrene Dressing, 301 Hospital Drive, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

Barbara B. Sparks

State
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

George W. ...
...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42737

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Julia Pierson

2. Date of Death

December 30, 1999

3. Time of Death

1:35 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-16-6738

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
7/19/16

9. Birthplace (State or Foreign Country)

Penn Co., Va.

Usual Residence of Decedent

10a. State
Md.10b. County
Prince George's10c. City, Town or Location
Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9601 Piscataway Rd.

10f. Zip Code

20735

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James Lovelace

18. Mother's Name (First, Middle, Maiden Surname)

Birdia Star

19a. Informant's Name/Relationship (Type, Print)

Georgia Hogue/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as # 10 above

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Forest Hills Mem. Gdns.

Date

1/8/00

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ESOPHAGEAL CARCINOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

FEW YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HypertensionNon-Insulin Dependent Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

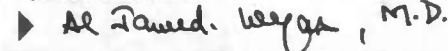
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 Al Jawad Waqas, M.D.

29c. License number

D00S2931

29d. Date signed (Month, Day, Year)

DECEMBER 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

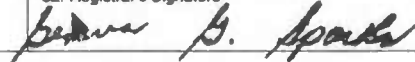
AL JAWAD WAQAS, 11119 ROCKVILLE PIKE, SUITE 100, ROCKVILLE MD 20852

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42738

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Warren Joseph PAYNE, Sr.				2. Date of Death Month Day Year December 27, 1999		3. Time of Death 4:45 am	
	4a. Facility Name (If not institution, give street and number) 470 West Dares Beach Road, Apt. 202				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 577 26 7995		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 23, 1921	
	9. Birthplace (State or Foreign Country) Wash., DC		10a. State MD		10b. County Calvert		10c. City, Town or Location Prince Frederick	
Usual Residence of Decedent								
10e. Street and Number 470 West Dares Beach Road, Apt. 202			10f. Zip Code 20678			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: white			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 11			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) substance abuse counselor		
16b. Kind of Business/Industry health			17. Father's Name (First, Middle, Last) James Edward Payne			18. Mother's Name (First, Middle, Maiden Surname) Theresa Elbert		
19a. Informant's Name/Relationship (Type, Print) Effie Payne/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, VA		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Adenocarcinoma of Right lung</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 2 months								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic obstructive lung disease</u> <u>coronary artery disease</u> <u>Peripheral vascular disease</u>								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>A.T. Munshi M.D. Physician</u>			29c. License number <u>D 19427</u>			29d. Date signed (Month, Day, Year) <u>12/27/99</u>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>A.T. Munshi, M.D.</u> <u>Suite 303, 110 2058 Road, Prince Frederick MD 20678</u>								
31. Date filed (Month, Day, Year) <u>DEC 30 1999</u>			32. Registrar's Signature <u>B. Sparks</u>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

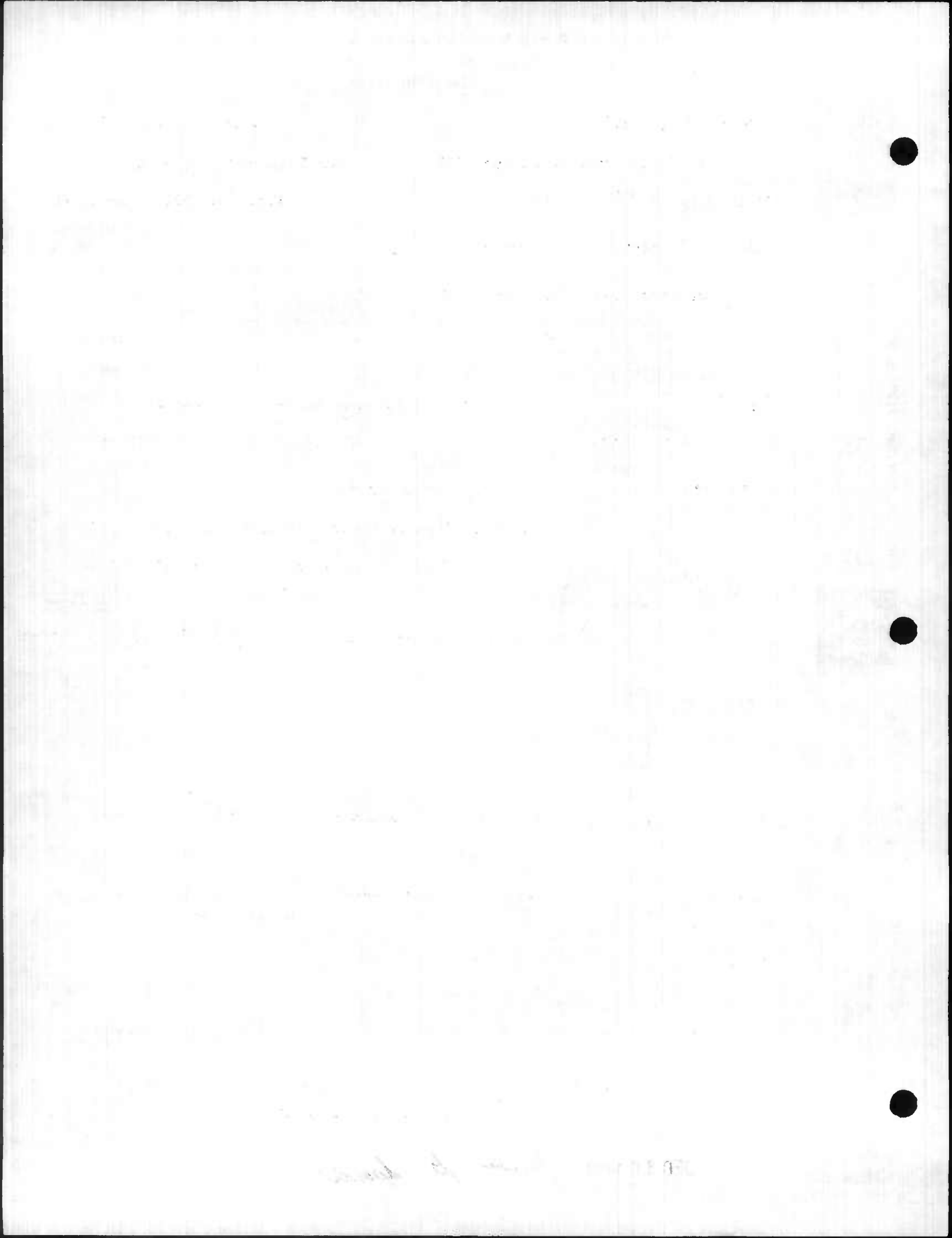
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



99 4.2739

**Physician
/Medical
Examiner**

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0005 6 0 WAC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42740

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EUNICE BLAND RIDGEWAY

2. Date of Death

December 30, 1999

3. Time of Death

11:34am

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

LaPlata

4c. County of Death

Charles

Funeral
Director

5. Social Security Number

215-48-1874

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

8. Date of Birth

June 3, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Charles

10c. City, Town or Location

LaPlata

10d. Inside City Limits

Yes ☒ No ☐

10e. Street and Number

6585 Horseshoe Drive

10f. Zip Code

20677

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Allen Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Marks

19a. Informant's Name/Relationship (Type, Print)

Dennis L. Thrift/ grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

S.R. 5, Box 395 C-1, LaPlata, Md. 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Welcome Grove Baptist Cem.

Date

Jan. 2, 2000

20c. Location - City or Town, State

Newland, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. EVANS FUNERAL HOME, INC 16000
ANNAPOLIS RD., BOWIE, MD. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Advanced Atherosclerosis

Due to (or as a consequence of):

b. Cerebral Vascular Disease

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

x yrs

1 Days

2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D - 20629

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George H. Wathen, MD

Pembroke Square, Suite 103
Waldorf, Maryland 20603

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

State
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23c-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-0000.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

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0005 E. O. MAL.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42741

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Anthony Rosekrans, Jr.						2. Date of Death Month Day Year DECEMBER 30, 1999		3. Time of Death 1700 PM	
	4a. Facility Name (If not institution, give street and number) 3505 Malec Lane						4b. City, Town, or Location of Death BOWIE		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 117-26-3009		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) 03-28-1935		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
10a. State Md.			10b. County Prince Georges			10c. City, Town or Location Bowie			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3505 Malec Lane						10f. Zip Code 20715		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-1958		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Financial Analyst				16b. Kind of Business/Industry IBM		
17. Father's Name (First, Middle, Last) Robert Anthony Rosekrans, Sr.						18. Mother's Name (First, Middle, Maiden Surname) Grace Keenan				
19a. Informant's Name/Relationship (Type, Print) Gerard Rosekrans/Brother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1446 Vineyard Court Crofton, Md. 21114-1133				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cem.			Date 01-05-00		20c. Location - City or Town, State Clinton, Maryland	
21. Signature of Funeral Service Licensee Shannon W. Beall Shannon W. Beall M00798						22. Name and Address of Facility Beall Funeral Home 6512 N.W. Crain Highway Bowie, Md. 20715				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER OF MOUTH & THROAT Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and Title of certifier [Signature]						29c. License number DME 033954		29d. Date signed (Month, Day, Year) JANUARY 03 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785										
31. Date filed (Month, Day, Year) JAN 04 2000						32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Handwritten signature or initials

0005 2 0 MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42742

AMENDED ITEM #19a PER FH G781 3/7/2000 AH

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Eversfield Swann

2. Date of Death

December 23, 1999

3. Time of Death

22:30 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

219-58-8126

8. Sex

M 2 F

7. Age (In yrs. last birthday)

47

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

October 9, 1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Suitland

10d. Inside City Limits

Yes 2 No

10e. Street and Number

4699 Homer Avenue Apt. #C

10f. Zip Code

20746

10g. Citizen of What Country?

U.S.A.

11. Marital Status

XX Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

Barber School

17. Father's Name (First, Middle, Last)

Joseph M. Swann

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Smith

19a. Informant's Name/Relationship (Type, Print)

Mrs. Harriett Dixon (Mother)
HARRIETT R. BUTLER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1618 Quarter Avenue Capital Heights, Maryland 20743

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hills Memorial Gardens, Inc.

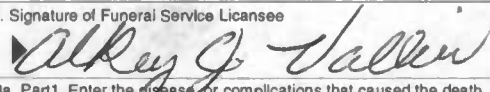
Date

1/3/2000

20c. Location (City or Town, State)

Clinton, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Rottins Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial Infarction c P.E.A.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

45 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypoxemic Acute Respiratory Failure

Due to (or as a consequence of):

60 min

c. Status Asthmaticus

Due to (or as a consequence of):

60 min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4X Unknown

24a. Was an autopsy performed?

1 Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2X No

25. Was case referred to medical examiner?

1 Yes 2X No

Hospital:

1X Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation
2 Accident 6 Could not be determined
3 Suicide
4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

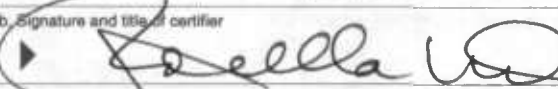
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D14399

29d. Date signed (Month, Day, Year)

12/28/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Colella, M.D. 3001 Hospital Drive Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2

Handwritten signature

JAN 6 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42743

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM W. SAUNDERS, JR.				2. Date of Death Month December Day 22 Year 1999		3. Time of Death 2:04 PM		
	4a. Facility Name (If not Institution, give street and number) PRINCE GEORGE'S COMMUNITY HOSPITAL				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 227-62-6300		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 26, 1945	9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent								
10a. State MD		10b. County Prince George's		10c. City, Town or Location Capital Heights			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1114 Castle Haven Court				10f. Zip Code 20743		10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Public School Supervisor		16b. Kind of Business/Industry P.G. County School System			
17. Father's Name (First, Middle, Last) Walter Saunders				18. Mother's Name (First, Middle, Maiden Surname) Sadie Tuck					
19a. Informant's Name/Relationship (Type, Print) Betty Saunders/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1114 Castle Haven Court, Capital Heights, MD 20743					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State Suitland, MD			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. arrhythmia Due to (or as a consequence of): b. hypertension Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>		29c. License number DS2222		29d. Date signed (Month, Day, Year) 12/28/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Meera Karhouwa - 3001 Hospital Drive, Cheverly, MD 20785									
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

State
Registrar

Handwritten signature or initials

0005 8 0 HME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42744

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia L. Shackelford

2. Date of Death

December 26, 1999

3. Time of Death

2:58pm

4a. Facility Name (If not institution, give street and number)

6601 Evanston St.

4b. City, Town, or Location of Death

Forestville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

248-72-0528

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

April 5, 1941

9. Birthplace (State or Foreign Country)

Landcaster, S.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6601 Evanston St.

10f. Zip Code

20747

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LPN

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Marion Fletcher

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Rodney Shackelford/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6601 Evanston St. Forestville, Md. 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

12/29/99

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Alexander S. Pope Funeral Homes
5538 Marlboro Pike/Forestville, Md.

20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

a. Due to (or as a consequence of):

b. Chronic Renal Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD 9565

29d. Date signed (Month, Day, Year)

December 30, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edger V. Potter, M.D. 1328 Southern Ave. S.E. S#210 Washington, D.C. 20032

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1957-1958

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42745

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BEULAH M SMITH						2. Date of Death Month Day Year DECEMBER 27, 1999		3. Time of Death 8:08 PM	
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER						4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 214 58 4842		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) MAY 2, 1937		9. Birthplace (State or Foreign Country) NORTH CAROLINA	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location CAPITAL HEIGHTS				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 6018 MARTIN LUTHER KING HIGHWAY APT 203						10f. Zip Code 20743		10g. Citizen of What Country? UNITED STATES		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) CARL COOK						18. Mother's Name (First, Middle, Maiden Surname) VIOLA ATKINS				
19a. Informant's Name/Relationship (Type, Print) JOSEPHINE SMITH						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7017 PALAMAR TURN, LANHAM MARYLAND 20706				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) FORT LINCOLN CEMETERY		20c. Location - City or Town, State 1-4-2000 BRENTWOOD, MARYLAND				
21. Signature of Funeral Service Licensee Raisa Dubinsky						22. Name and Address of Facility FORT LINCOLN FUNERAL HOME INC 3401 BLADENSBURG RD BRENTWOOD MD 20722				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic CANCER Due to (or as a consequence of): b. Lung CANCER Due to (or as a consequence of): c. END STAGE LIVER DISEASE Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALCOHOLISM Diabetes Mellitus Hypertension								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and Title of certifier [Signature]						29c. License number D 30666		29d. Date signed (Month, Day, Year) 12/29/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. BEOEAU 1450 MERCANTILE LANE, LARGO MD 20774										
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Handwritten signature

0005 + 0 MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42746

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert Emmett Sheahan				2. Date of Death Month Day Year December 28, 1999				3. Time of Death 7:40 pm	
	4a. Facility Name (If not institution, give street and number) 13214 Ronehill Drive				4b. City, Town, or Location of Death Beltsville				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577 60 5858		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) June 5, 1915		9. Birthplace (State or Foreign Country) Wash., DC	
	Usual Residence of Decedent 10a. State MD 10b. County Calvert 10c. City, Town or Location North Beach 10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 9131 Frederick Avenue		10f. Zip Code 20714		10g. Citizen of What Country? USA	
To Be Completed by Funeral Director	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1941-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) mail clerk				16b. Kind of Business/Industry US Postal Svc.			
	17. Father's Name (First, Middle, Last) Timothy Joseph Sheahan				18. Mother's Name (First, Middle, Maiden Surname) Mary Frances Garner					
	19a. Informant's Name/Relationship (Type, Print) Mary Margaret Cornwell/neice				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15301 Beaverbrook Ct., Apt. 3D, Silver Spring, MD 20906					
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		Date 1-3-00		20c. Location - City or Town, State Bladensburg, MD			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>pancreatic cancer</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 15 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Brother's home							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 121463		29d. Date signed (Month, Day, Year) 12-29-99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRUCE A. SILVER, MD 110 HOSPITAL RD, PRINCE FREDERICK, MD, 20678										
State Registrar	31. Date filed (Month, Day, Year) DEC 30 1999				32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

20 1VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42747

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Linwood

2. Date of Death

Month

Day

Year

3. Time of Death

12 30 99 6:00 Am.

4a. Facility Name (If not institution, give street and number)

3617 Brantley Road

4b. City, Town, or Location of Death

Pocomoke

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

214-30-8092

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8-31-33

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3617 Brantley Rd.

10f. Zip Code

21851

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farm Labor

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Eddie Thomas Tull

18. Mother's Name (First, Middle, Maiden Surname)

Mary Marshall

19a. Informant's Name/Relationship (Type, Print)

Lillian Tull (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 202 Pocomoke City, Md. 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Pauls Cemetery

Date

1-8-00

20c. Location - City or Town, State

Stafford Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home
P.O. Box 331 Pocomoke City, Md. 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Natural Causes

Due to (or as a consequence of):

b. A.O.M.

Due to (or as a consequence of):

c. ASCVD

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

024924

29d. Date signed (Month, Day, Year)

1/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ritchie C. Shoemaker MD

31. Date filed (Month, Day, Year)

JAN 07 2000

32. Registrar's Signature

Benita B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42748**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GERTRUDE TANNER				2. Date of Death Month December Day 24 Year 1999				3. Time of Death 12:43AM																																						
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel				4c. County of Death Prince George's																																						
Funeral Director	5. Social Security Number 103-01-8323		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 03-19-19		9. Birthplace (State or Foreign Country) Pennsylvania																																						
	Usual Residence of Decedent																																														
10a. State Maryland		10b. County Howard		10c. City, Town or Location Jessup				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																							
10e. Street and Number 8229 Washington Blvd., #8				10f. Zip Code 20794				10g. Citizen of What Country? U.S.A.																																							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White																																							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Telephone				16b. Kind of Business/Industry General Services Administration																																							
17. Father's Name (First, Middle, Last) Hewitt				18. Mother's Name (First, Middle, Maiden Surname) Helen Litchmounger																																											
19a. Informant's Name/Relationship (Type, Print) Valerie Hope Tanner - Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8229 Washington Blvd., #8, Jessup, MD 20794																																											
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory				20c. Location - City or Town, State 01/05/00 Alexandria, Virginia																																							
21. Signature of Funeral Service Licensee Claudette A. Douch				22. Name and Address of Facility Gasch's Funeral Home 4739 Baltimore Avenue, Hyattsville, MD 20781																																											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																															
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="8">a. Sepsis Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death Few days</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="8">b. Cardiac arrest Due to (or as a consequence of):</td> <td>6 day</td> </tr> <tr> <td colspan="8">c. Respiratory Failure. Due to (or as a consequence of):</td> <td>6 day.</td> </tr> <tr> <td colspan="8">d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. Sepsis Due to (or as a consequence of):								Approximate Interval Between Onset and Death Few days	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cardiac arrest Due to (or as a consequence of):								6 day	c. Respiratory Failure. Due to (or as a consequence of):								6 day.	d.								
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis Due to (or as a consequence of):								Approximate Interval Between Onset and Death Few days																																						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cardiac arrest Due to (or as a consequence of):									6 day																																				
		c. Respiratory Failure. Due to (or as a consequence of):									6 day.																																				
		d.																																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																																							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																							
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)																																							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier [Signature]				29c. License number 042580																																							
				29d. Date signed (Month, Day, Year) 12-24-99.																																											
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) P S BURSA 832 Annapolis Rd #13 BELLEVILLE MD 20710																																															
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature [Signature]																																											

To Be Completed by Funeral Director

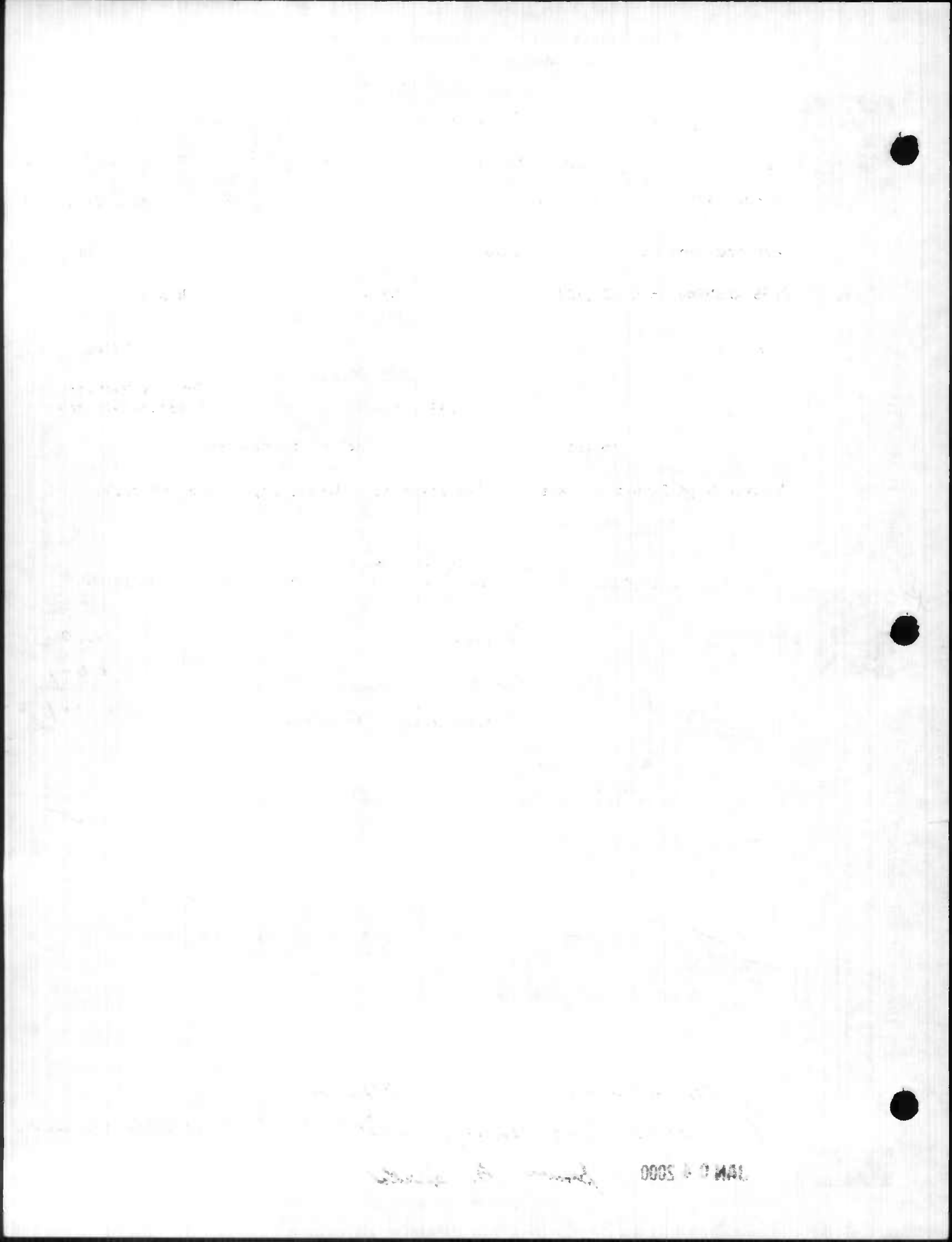
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



[Faint, illegible handwritten text]

JAN 4 1980

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42749

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Calvin D Wilson		2. Date of Death Month December Day 31 , Year 1999		3. Time of Death 12:40 P.M.						
	4a. Facility Name (If not institution, give street and number) 24459 Nanticoke Road		4b. City, Town, or Location of Death Quantico		4c. County of Death Wicomico						
Funeral Director	5. Social Security Number 229-98-0014	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year Months 08 Days 12	If Under 24 Hrs. Hours 56 Min.						
	8. Date of Birth (Month, Day, Year) 08 12 56										
9. Birthplace (State or Foreign Country) VIRGINIA											
Usual Residence of Decedent											
10a. State md		10b. County Wicomico		10c. City, Town or Location Quantico							
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number 24459 Nanticoke Rd			10f. Zip Code 21856		10g. Citizen of What Country? United States						
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4or 5+)									
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disable		16b. Kind of Business/Industry Disable									
17. Father's Name (First, Middle, Last) Calvin P. Wilson			18. Mother's Name (First, Middle, Maiden Surname) Catherine Matthews								
19a. Informant's Name/Relationship (Type, Print) Calvin P. Wilson Father			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24459 Nanticoke Rd Quantico, md 21856								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Tavernacle BAPT CH		20c. Location - City or Town, State 1-8-00 HORTON, VA							
21. Signature of Funeral Service Licensee Samuel H. Savage			22. Name and Address of Facility WILKINSON FUNERAL HOME 22171 Wharton Rd ACCOMAC, VA 23001								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. PERITONITIS</td> <td rowspan="4">Approximate interval between Onset and Death</td> </tr> <tr> <td>b. VOLVULUS</td> </tr> <tr> <td>c. </td> </tr> <tr> <td>d. </td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)	a. PERITONITIS	Approximate interval between Onset and Death	b. VOLVULUS	c.	d.
Immediate Cause (Final disease or condition resulting in death)	a. PERITONITIS	Approximate interval between Onset and Death									
	b. VOLVULUS										
	c.										
	d.										
<table border="1"> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table>						Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		Due to (or as a consequence of):		
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):										
	Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year)		28b. Time of Injury M							
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Margaret Dorey Hall M.D.			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) January 05, 2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JAN 06 2000		32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend # 23a. Per Phys. PGC 1-5-00 cr

Certificate of Death

Reg. No.

99 42750

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alphonso R. Williams, Jr.				2. Date of Death Month Day Year December 22 1999		3. Time of Death 4:35 p.m.	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 577 68 5881	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	8. Date of Birth (Month, Day, Year) May 30, 1951	9. Birthplace (State or Foreign Country) Washington DC			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Hillcrest Heights		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 3392 Curtis Drive #202		10f. Zip Code 20746		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plasterer		16b. Kind of Business/Industry Government			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Alphonso R. Williams, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Anna Jones			
	19a. Informant's Name/Relationship (Type, Print) Alphonso R. Williams, Sr./father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3392 Curtis Dr. #202 Hillcrest Heights, MD 20746			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cem		20c. Location - City or Town, State Suitland, Maryland		20d. Date 12-29	
	21. Signature of Funeral Service Licensee <i>Symbolyus Scofield</i>		22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. ASPIRATION Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 DAYS 2 DAYS							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE END STAGE RENAL FAILURE							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <i>Regan Chd Rm</i>		29c. License number D 50653		29d. Date signed (Month, Day, Year) 12/24/99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN C. SURANA 5851 DEALE CHURCHTON ROAD DEALE MD 20751							
31. Date filed (Month, Day, Year) JAN 0 5 2000		32. Registrar's Signature <i>B. Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

0005 2 0 WRL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42751

Amend #'s 19a. & 19b. Per FH PGC 1-6-00 cr

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louis Wells				2. Date of Death Month 12 Day 31 Year 99		3. Time of Death 7:20 am	
	4a. Facility Name (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL				4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 149-26-2837		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-27-1935	9. Birthplace (State or Foreign Country) New Jersey
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capitol Heights		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 4306 Will Street				10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Private			
	17. Father's Name (First, Middle, Last) John Lee Wells				18. Mother's Name (First, Middle, Maiden Surname) Susie Sibert			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) John Wells / Son Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4306 Will Street, Capitol Heights, Maryland 20743			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date 01/08 2000		20c. Location - City or Town, State Brentwood, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): RESPIRATORY FAILURE Due to (or as a consequence of): BRONCHOGENIC CARCINOMA Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INSULIN DEPENDENT DIABETES MELLITUS PERIPHERAL VASCULAR DISEASE SCHIZOPHRENIA							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number D34498		29d. Date signed (Month, Day, Year) JAN 2, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HENRI TERESA DE LA BAUME 7700 OLD BRANCH AVE. STC B-102							
State Registrar	31. Date filed (Month, Day, Year) JAN 05 2000		32. Registrar's Signature  CLINTON, MD. 20735					

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene **99 42752**
Certificate of Death Reg. No.

99 42752

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

⑤

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

Dear Mr. [Name] [Address] [City] [State] [Zip]

Very truly yours,
[Signature]
[Name]
[Title]
[Company]
[Address]
[City] [State] [Zip]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42753

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JAMES WASSON				2. Date of Death Month Day Year December 27, 1999		3. Time of Death 12:45 p.m.		
	4a. Facility Name (If not institution, give street and number) 531 James Avenue				4b. City, Town, or Location of Death Tracy's Landing		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 577 26 9235		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 29, 1922		
	9. Birthplace (State or Foreign Country) PA		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Tracy's Landing		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 531 James Avenue		10f. Zip Code 20779		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) electrician		16b. Kind of Business/Industry commercial construction					
17. Father's Name (First, Middle, Last) William Paul Wasson				18. Mother's Name (First, Middle, Maiden Surname) Agnes Sharp Balentine Stewart					
19a. Informant's Name/Relationship (Type, Print) Linda W. Savage (daug.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1230 Old Landing Rd., Accokeek, MD 20607					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Date 12-28-99		20d. Location - City or Town, State Alexandria, VA			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Cerebrovascular Accident Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate interval between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 047610		29d. Date signed (Month, Day, Year) December 28 1999			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David Tardio, M.D. Prince Frederick, MD 20678									
31. Date filed (Month, Day, Year) DEC 30 1999		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10 1VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42754

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH WALL				2. Date of Death Month Day Year DECEMBER 29, 1999		3. Time of Death 09:15am	
	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital				4b. City, Town, or Location of Death Prince Frederick		4c. County of Death Calvert	
Funeral Director	5. Social Security Number 219-56-2079		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) July 29, 1952	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Lusby	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1890 Sollers Wharf Road		10f. Zip Code 20657		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) Joseph C. Wall		18. Mother's Name (First, Middle, Maiden Surname) Susie King					
	19a. Informant's Name/Relationship (Type, Print) Vera Johnson/Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 151 Lusby, MD 20657					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Brown's Church Cemetery		20c. Location - City or Town, State Port Republic, MD			
	21. Signature of Funeral Service Licensee Blanche A. Sewell		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Esophageal Cancer						Approximate Interval Between Onset and Death 8 months	
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Bruce Silver MD		29c. License number 021463		29d. Date signed (Month, Day, Year) 12-29-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. BRUCE SILVER, MD PRINCE FREDERICK, MD 20678								
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done and is intended to give a general impression of the progress of the work.

2. The second part of the report deals with the results of the work done during the year. It is a summary of the results of the work and is intended to give a general impression of the progress of the work.

3. The third part of the report deals with the conclusions drawn from the work done during the year. It is a summary of the conclusions drawn from the work and is intended to give a general impression of the progress of the work.

4. The fourth part of the report deals with the recommendations made during the year. It is a summary of the recommendations made during the year and is intended to give a general impression of the progress of the work.

5. The fifth part of the report deals with the future work planned for the next year. It is a summary of the future work planned for the next year and is intended to give a general impression of the progress of the work.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42755

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anne Lanzoni Young						2. Date of Death Month Day Year December 31, 1999		3. Time of Death 11:30AM	
	4a. Facility Name (If not Institution, give street and number) 5911 John Adams Drive						4b. City, Town, or Location of Death Temple Hills		4c. County of Death Prince George's Co.	
Funeral Director	5. Social Security Number 042 22 1021		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Dec 17, 1927		9. Birthplace (State or Foreign Country) Hamden, CT	
	Usual Residence of Decedent									
10a. State MD		10b. County P.G.		10c. City, Town or Location Temple Hills				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 5911 John Adams Drive				10f. Zip Code 20748				10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary 12 Secondary (0-12) 4 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher				16b. Kind of Business/Industry P.G. County Schools		
17. Father's Name (First, Middle, Last) Eneas Lanzoni						18. Mother's Name (First, Middle, Maiden Surname) Rose Vacca				
19a. Informant's Name/Relationship (Type, Print) Arthur F. Young (HUSBAND)						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5911 John Adams Drive, Temple Hills, Maryland 20748				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lee Crematory Jan 3, 2000		20c. Location - City or Town, State Clinton, Maryland				
21. Signature of Funeral Service Licensee						22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac Arrest Due to (or as a consequence of): b. Valvular Heart disease, Severe Due to (or as a consequence of): c. Polycythemia Vera. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to Immediate Cause (Disease or Injury that initiated events resulting in death) List										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No N/A		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
				28d. Describe how injury occurred						
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Dr. J. Smith Jr.				29c. License number VA. 01018898		29d. Date signed (Month, Day, Year) 1-03-2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HECTOR F. SMITH JR. MD 5226 Dawes Ave. Alex										
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature B. Smith						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42756

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Woodrow Wilson Adkins				2. Date of Death Month Day Year Dec. 29, 1999		3. Time of Death 2:45 A.M.	
4a. Facility Name (If not institution, give street and number) 27490 Little Lane				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
5. Social Security Number 214-32-2352		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 1-15-1916	9. Birthplace (State or Foreign Country) Md.
Usual Residence of Decedent							
10a. State Md.		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 27490 Little Lane				10f. Zip Code 21801		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) State Road Foreman		16b. Kind of Business/Industry Highway Dept.	
17. Father's Name (First, Middle, Last) Charles Adkins				18. Mother's Name (First, Middle, Maiden Summa) Florence Nicholson Adkins			
19a. Informant's Name/Relationship (Type, Print) Blanche E. Adkins, Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27490 Little Lane, Salisbury, Md. 21801			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Riverton Cemetery		Date 12-31-99		20c. Location - City or Town, State Mardela Springs, Md.	
21. Signature of Funeral Service Licensee <i>William M. Hart</i>				22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <i>ccf -> congestive Heart Failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Arteriosclerosis</i> a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <i>DM</i> <i>H. Block</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D2536		29d. Date signed (Month, Day, Year) 12/29/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 Enatelyn Shore Drive, Salisbury, MD							
31. Date filed (Month, Day, Year) DEC 29 1999		32. Registrar's Signature <i>[Signature]</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42757

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kristen Chester					2. Date of Death Month Day Year 12 - 22 - 99		3. Time of Death 1715				
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER					4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO				
Funeral Director	5. Social Security Number		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) ZERO Yrs.		8. Date of Birth (Month, Day, Year) 12-22-99		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent					10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury		
					10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10a. Street and Number 704 Richmond Avenue					10f. Zip Code 21801		10g. Citizen of What Country? U.S.A					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None			16b. Kind of Business/Industry None				
17. Father's Name (First, Middle, Last) Jermaine Chester					18. Mother's Name (First, Middle, Maiden Surname) Leslie James							
19a. Informant's Name/Relationship (Type, Print) Jermaine Chester (Father)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Richmond Ave. Salisbury, Md. 21801							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Mem. Garden			20c. Location - City or Town, State Hebron, Md.		20d. Date 12/24/99		
21. Signature of Funeral Service Licensee Gladys B. Stewart					22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pre viable Premature Infant Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 2 hours		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
					28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier S. Gupta, MD					29c. License number D-33182			29d. Date signed (Month, Day, Year) 12/22/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GUPTA, MD. PENINSULA REGIONAL MEDCTR, SALISBURY, MD.												
31. Date filed (Month, Day, Year) DEC 27 1999					32. Registrar's Signature Berna G. Sparks							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

99 42758

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CORA ELIZABETH CAVEY				2. DATE OF DEATH MONTH DAY YEAR DEC. 19 1999				3. TIME OF DEATH 9:55 A M	
4. SOCIAL SECURITY NUMBER 220-18-0332		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 90 YRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 29, 1909		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Manokin Manor Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Princess Anne			9c. COUNTY OF DEATH Somerset		
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 105 Coulbourn Drive				10f. ZIP CODE 21804		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) seamstress		16. KIND OF BUSINESS/INDUSTRY Shirt Factory					
17. FATHER'S NAME (First, Middle, Last) J. Frank Cutsail				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cenie B. Gue					
19a. INFORMANT'S NAME (Type/Print) Shirley Lambertson/daughter				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8612 Whitesville RD - Pittsville, MD 21850					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Paul's U.M. Ch. Cem. 12/22		20c. LOCATION — City or Town, State Wenona, Maryland		22. NAME AND ADDRESS OF FACILITY 1213 Jersey Road - Salisbury MD 21801			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia A. Jolley</i>				22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL MD 21801					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Massive Ischemic CVA of right parietal lobe, Decubital and Basal Ganglia</i> Approximate Interval Between Onset and Death 25 days Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus Type II. Atrial Fibrillation. Senile Dementia</i>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio M. Bellosso, MD</i>				29c. LICENSE NUMBER D 29505		29d. DATE SIGNED (Month, Day, Year) 12-19-99			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801									
31. DATE FILED (Month, Day, Year) DEC 23 1999		32. REGISTRAR'S SIGNATURE <i>Benita G. Sparks</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CORA ELIZABETH CAVEY
December 19, 1999 @ 9:55am

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42759

AMENDED #26, 01-04-00,(per MD), SRR, TALBOT

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

RONALD COLLIER

2. Date of Death

Month
DecDay
28Year
1999

3. Time of Death

2356

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

391-34-3411

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
April 16, 1937

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Maryland

10b. County

Talbot

10c. City, Town or Location

McDaniel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9072 New Rd.

10f. Zip Code

21647

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

U.S.

Coast Guard

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Marine Mechanic

17. Father's Name (First, Middle, Last)

Alfred Collier

18. Mother's Name (First, Middle, Maiden Surname)

Idella May

19a. Informant's Name/Relationship (Type, Print)

G. Rene Rishel Stepdaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

901 #1 Riverview Terrace St. Michael, Md. 21663

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Olivet Cemetery Dec. 31, 1999

Date

20c. Location - City or Town, State

St. Michaels, Maryland

21. Signature of Funeral Service Licensee

Harrison E. Leonard

22. Name and Address of Facility

Harrison E. Leonard Funeral Home
312 S. Talbot St. St. Michaels, Md. 21663

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Arteriosclerotic Cardiovascular Disease

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David A. Stout, M.D.

29c. License number

D06804

29d. Date signed (Month, Day, Year)

12/29/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Allan Stout, M.D. 219 S. Washington St., Easton, MD 21601

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

B. Sparks

Ronald Collier
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

99 42760

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Richard Lee Davis</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Dec 19 1999</i>				3. TIME OF DEATH <i>915 P M</i>	
4. SOCIAL SECURITY NUMBER <i>225-04-6222</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>39</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Mar 8 1960</i>		8. BIRTHPLACE (State or Foreign Country) <i>Assawoman VA</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>32685 Costen Road</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Westover</i>				9c. COUNTY OF DEATH <i>Somerset</i>	
10a. STATE <i>MD</i>				10b. COUNTY <i>Somerset</i>		10c. CITY, TOWN OR LOCATION <i>Westover</i>			
10e. STREET AND NUMBER <i>32685 Costen Road</i>				10f. ZIP CODE <i>21871</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10th</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Production laborer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Poultry Company</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Fred Earl Davis</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Hassie Mae Sheppard</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Rose M. Davis</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>32685 Costen Rd Westover MD 21871</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Christ AME Cemetery</i>		20c. LOCATION — City or Town, State <i>Rehoboth MD</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> (M00071)				22. NAME AND ADDRESS OF FACILITY <i>Morris Funeral Services (Harris-Neck) PO Box 27 Bridgeville DE 19933</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Malignant Lymphoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD 29c. LICENSE NUMBER <i>D22278</i> 29d. DATE SIGNED (Month, Day, Year) <i>12-20-99</i> 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type, Print) <i>David Carroll, MD 145E. Carroll St. Solish, MD 21801</i> 31. DATE FILED (Month, Day, Year) <i>DEC 20 1999</i> 32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42761

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLADYS ANN FOSTER				2. Date of Death Month Day Year December 22, 1999		3. Time of Death 6522	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 217-10-2225		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) April 12, 1915	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 6139 Florence Ave.		10f. Zip Code 21801		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (14 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Presser		16b. Kind of Business/Industry Shirt Factory			
	17. Father's Name (First, Middle, Last) Harry Baker				18. Mother's Name (First, Middle, Maiden Surname) Mary Frances Cook			
	19a. Informant's Name/Relationship (Type, Print) Bertha Gordy/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Madison St., Salisbury, MD 21804			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens		20c. Date 12/27/99		20d. Location - City or Town, State Hebron, MD	
	21. Signature of Funeral Service Licensee David H. Thompson M01051		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cerebro-vascular accident (Stroke) days Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier Jeffrey B. Thornton, MD				29c. License number D 36783		29d. Date signed (Month, Day, Year) 12/21/99	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey B. Thornton, MD - PRMC Salisbury MD 21804				31. Date filed (Month, Day, Year) DEC 23 1999			
	32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42762

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

JACKIE

LYNN

GRIFFIN

2. Date of Death

Month

Day

Year

December

16

1999

3. Time of Death

0710

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

217-52-2459

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 4, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4775 Airport Rd.

10f. Zip Code

21804

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Oscar Lee Griffin Jr./Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4775 Airport Rd., Salisbury, MD 21804

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

12/16/99

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

Kath R. K...
Kath R. K...

22. Name and Address of Facility

Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Liver Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

c. Hyponatremia

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hx of ETOH Abuse

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. Davis MD

29c. License number

D50054127

29d. Date signed (Month, Day, Year)

12/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Davis 3 Bishop Blvd Delmar MD.

31. Date filed (Month, Day, Year)

DEC 17 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

penn. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Jackie Griffin

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #20b, 01-04-00(per FD), State of Maryland / Department of Health and Mental Hygiene
SRR, Talbot

Certificate of Death

Reg. No. 99 42763

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) **HATTIE J. GRANBY** 2. Date of Death Month **Dec** Day **27** Year **1999** 3. Time of Death **1516**

Funeral
Director

4a. Facility Name (If not institution, give street and number) **The Memorial Hospital** 4b. City, Town, or Location of Death **Easton** 4c. County of Death **Talbot**

5. Social Security Number **213-22-8449** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **98** Yrs. 8. Date of Birth (Month, Day, Year) **March 15, 1901** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent 10a. State **Maryland** 10b. County **Talbot** 10c. City, Town or Location **St. Michaels** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **205 Dodson Ave.** 10f. Zip Code **21663** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **Black**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **7** Collega (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Domestic Seafood Worker** 16b. Kind of Business/Industry **Seafood**

17. Father's Name (First, Middle, Last) **Franklin Clark** 18. Mother's Name (First, Middle, Maiden Sumema) **Cornelia Bailey**

19a. Informant's Name/Relationship (Type, Print) **Bernice Butler Daughter** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **P.O. Box 525 St. Michaels, Maryland 21663**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **THOMAS CEMETERY** Date **Jan. 3, 2000** 20c. Location - City or Town, State **St. Michaels, Md. 21663**

21. Signature of Funeral Service Licensee **Harrison E. Leonard** 22. Name and Address of Facility **Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. **DYSRHYTHMIA** Due to (or as a consequence of): **MINUTES**

b. **RENAL FAILURE** Due to (or as a consequence of): **MONTHS**

c. **INSULIN DEPENDENT DIABETES** Due to (or as a consequence of): **YEARS**

d. **CORONARY ARTERY DISEASE** Due to (or as a consequence of): **YEARS**

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **MAKAS** 29c. License number **H48241** 29d. Date signed (Month, Day, Year) **12/28/99**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **DANIELE E. MAKAS, PO SOBIOLEWILS AVE EASTON, MD 21601**

31. Date filed (Month, Day, Year) **JAN 04 2000** 32. Registrar's Signature **B. Sparks**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Hattie Granby

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42764

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Otis Hopkins

2. Date of Death

Month Day Year

12

10

99

3. Time of Death

2:00 pm

4a. Facility Name (If not institution, give street and number)

11540-Old School Rd

4b. City, Town, or Location of Death

Mardel Springs

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

217-08-3408

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

12-1-06

9. Birthplace (State or Foreign Country)

DELAWARE

Usual Residence of Decedent

10a. State

Md

10b. County

Wicomico

10c. City, Town or Location

MARDEL SPRINGS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11540-Old School Rd.

10f. Zip Code

21837

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ENVIRONMENTAL SERVICES

16b. Kind of Business/Industry

BOARD OF EDUCATION

17. Father's Name (First, Middle, Last)

LEONARD HOPKINS

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA GOSLEE HOPKINS

19a. Informant's Name/Relationship (Type, Print)

PATRICIA WINDER / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

POB 401 HEBRON, MARYLAND 21830

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ZION Church CEMETARY

Date

12/18/99

20c. Location - City or Town, State

SHARPTOWN, MD.

21. Signature of Funeral Service Licensee

Bennie Smith

22. Name and Address of Facility

BENNIE SMITH FUNERAL HOME
917-W. ISABELLE ST. SALISBURY MD, 21801

23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

stroke, or heart failure. List only one cause on each line.

Immediate Cause (Final
disease or condition
resulting in death)

a. Due to (or as a consequence of):

ASVD

Approximate
Interval Between
Onset and Death

5 min

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diagnosed Alzheimer's Disease.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bennie Smith

29c. License number

DR6612

29d. Date signed (Month, Day, Year)

12-15-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. J. Crouch, 105 Pine Bluff, Salisbury MD 21801

State
Registrar

31. Date filed (Month, Day, Year)

DEC 16 1999

32. Registrar's Signature

Bennie Smith

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42765

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VAUGHN EMORY HITCHENS				2. Date of Death Month DEC. Day 31 Year 1999		3. Time of Death 9:20 A.M.	
	4a. Facility Name (If not institution, give street and number) SALISBURY CENTER:GENESIS ELDERCARE				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 222-09-7199		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 7-6-1918	9. Birthplace (State or Foreign Country) Md.
	Usual Residence of Decedent							
10a. State Md.		10b. County Wicomico		10c. City, Town or Location Delmar			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 412 E. Walnut St.				10f. Zip Code 21875		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Service Technician		16b. Kind of Business/Industry Laundry		
17. Father's Name (First, Middle, Last) Arthur Hitchens				18. Mother's Name (First, Middle, Maiden Surname) Mary Wilson Hitchens				
19a. Informant's Name/Relationship (Type, Print) Vonette Breeden, Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 E. Walnut St., Delmar, Md. 21875				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Stephens Cem. Park		Date 1-4-2000		20c. Location - City or Town, State Delmar, De.
21. Signature of Funeral Service Licensee <i>William M. Shortz</i>				22. Name and Address of Facility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940-1114				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. GASTROINTESTINAL BLEEDING Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death 2 days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC PROSTATE CANCER								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Robert Allen, M.D.</i>		29c. License number D29168		29d. Date signed (Month, Day, Year) 1/3/00
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ROBERT ALLEN, M.D.-200 CIVIC AVENUE, SALISBURY, MD 21804								
31. Date filed (Month, Day, Year) JAN 03 2000				32. Registrar's Signature <i>G. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42766

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAROLD HERSHEY				2. Date of Death Month Day Year DECEMBER 31, 1999				3. Time of Death 1218 P.		
	4a. Facility Name (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL				4b. City, Town, or Location of Death BERLIN				4c. County of Death WORCHESTER		
Funeral Director	5. Social Security Number 080-18-6208		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 30, 1925		9. Birthplace (State or Foreign Country) NEW YORK CITY, NY		
	Usual Residence of Decedent										
10a. State DELAWARE		10b. County SUSSEX		10c. City, Town or Location FRANKFORD				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 25 CLAMSHELL LANE				10f. Zip Code 19945				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MANAGER & SALESMAN				16b. Kind of Business/Industry AUTOMOBILE SALES			
17. Father's Name (First, Middle, Last) VICTOR COHEN				18. Mother's Name (First, Middle, Maiden Surname) MAY HERSHEY							
19a. Informant's Name/Relationship (Type, Print) HELENE S. HERSHEY				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 CLAMSHELL LANE, FRANKFORD, DE 19945							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EASTERN SHORE CREMATORIUM		Date 01/03/99		20c. Location - City or Town, State LEWES, DELAWARE					
21. Signature of Funeral Service Licensee <i>MOO 866</i>		22. Name and Address of Facility PARSELL FUNERAL HOMES & CREMATORIUM 1449 KINGS HIGHWAY, LEWES, DE 19958									
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) ASCVD										Years	
Due to (or as a consequence of): Hypertension										Years	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Due to (or as a consequence of):											
Due to (or as a consequence of):											
Due to (or as a consequence of):											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 028769				29d. Date signed (Month, Day, Year) 1/1/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas N. Borodulin MD 1209 Ocean Highway Fawcett Island, DE 19744											
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature <i>[Signature]</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42767

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>CAROLYN Hopkins</i>				2. Date of Death Month <i>12</i> Day <i>16</i> Year <i>99</i>		3. Time of Death <i>12:30 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>204 E Chestnut St</i>				4b. City, Town, or Location of Death <i>DELMAR</i>		4c. County of Death <i>Wicomico</i>	
Funeral Director	5. Social Security Number <i>222-24-9701</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>59</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>7-24-40</i>	9. Birthplace (State or Foreign Country) <i>DEL.</i>
	Usual Residence of Decedent							
10a. State <i>md</i>		10b. County <i>Wicomico</i>		10c. City, Town or Location <i>Fruitland</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>111 Apt 1A Linda Dr.</i>				10f. Zip Code <i>21826</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Hispanic - AMERICAN</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HEALTH AID</i>		16b. Kind of Business/Industry <i>Home care provider</i>		
17. Father's Name (First, Middle, Last) <i>EMILSON GRAB</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ROSABIA BARKS</i>				
19a. Informant's Name/Relationship (Type, Print) <i>DALLAN Ashley</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>122 LINDEN CT DUNKER DEL 19901</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>MT CALVARY CH CEMETERY Fruitland Md.</i>		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <i>John A. Prince</i>				22. Name and Address of Facility <i>BENNIE SMITH 7/H 917 West ISABELLA ST Salisbury md</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic Pancreatic Cancer Three months</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature] MD</i>				29c. License number <i>D-39813</i>		29d. Date signed (Month, Day, Year) <i>12/21/99</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type Print) <i>M. ATKINS MD 1104 Westbury Drive Solis MD 21084</i>								
31. Date filed (Month, Day, Year) <i>DEC 22 1999</i>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42768

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER KENDALL HASTINGS

2. Date of Death

Month Day Year
December 21st 1999

3. Time of Death

06:20 a.m.

4a. Facility Name (If not institution, give street and number)

Wicomco Nursing Home

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomco

Funeral
Director

5. Social Security Number

217-10-3939

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

SEPT. 13, 1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1502 LILAC DR.

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

SELF-EMPLOYED

17. Father's Name (First, Middle, Last)

MONITOR WESLEY HANDY HASTINGS

18. Mother's Name (First, Middle, Maiden Sumama)

MARY LUCY ADAMS

19a. Informant's Name/Relationship (Type, Print)

JOHN H. WILLIAMS - GRANDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

128 E. MAIN ST. SALISBURY, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SPRINGHILL MEMORY GARDENS

Date

12/24/99

20c. Location - City or Town, State

HEBRON, MARYLAND

21. Signature of Funeral Service Licensee

B. Keith Phyllis CFSP

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC.

705 E. MAIN ST.

SALISBURY, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Cardiovascular Disease
Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregorio M. Belloso MD

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

12-21-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DRIVE, SALISBURY, MD 21801

State
Registrar

31. Date filed (Month, Day, Year)

DEC 22 1999

32. Registrar's Signature

B. Keith Phyllis

Walter K. Hastings
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42769

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDMUND J. HOFFMAN				2. Date of Death Month Day Year December 13 1999		3. Time of Death 06:10 PM.		
	4a. Facility Name (If not institution, give street and number) Shock Trauma Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 215-44-3246		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 15, 1924		
	9. Birthplace (State or Foreign Country) ALTOONA, PA		10a. State DE		10b. County SUSSEX		10c. City, Town or Location LEWES		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 307 MULBERRY LANE		10f. Zip Code 19958		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates 10/1943 05/1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR		16b. Kind of Business/Industry CIVIL SERVICE		17. Father's Name (First, Middle, Last) CARL V. HOFFMAN		18. Mother's Name (First, Middle, Maiden Surname) MARGUERITE M. MONAHAN	
19a. Informant's Name/Relationship (Type, Print) ROSANNA C. HOFFMAN, WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 387 MULBERRY LANE, SANDY BRAE, LEWES, DE 19958		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. Location - City or Town, State 12/17/99 SUITLAND, MD	
21. Signature of Funeral Service Licensee MO0866 <i>[Signature]</i>		22. Name and Address of Facility PARSELL FUNERAL HOME & CREMATORIUM, INC. 1449 KINGS HIGHWAY, LEWES, DE 19958		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month/Day/Year) 12/13/99		28b. Time of Injury 1536 M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred pedestrian struck by motor vehicle		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) street; Rt. 665		28f. Location (Street and Number or Rural Route Number, City or Town, State) Anne Arundel County, Md			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> M.D.		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) December 14, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner		31. Date filed (Month, Day, Year) DEC 17 1999		32. Registrar's Signature <i>[Signature]</i>		33. Address 111 Penn Street, Baltimore, Maryland 21201			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42770

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GERTRUDE RITA HEAPS

2. Date of Death

Month Day Year
DECEMBER 15, 1999

3. Time of Death

3:50 A.M.

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING CENTER

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

221-16-9051

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
MARCH 3, 1918

9. Birthplace (State or Foreign Country)

TRAINER, PA

Usual Residence of Decedent

10a. State

DE

10b. County

SUSSEX

10c. City, Town or Location

SELBYVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3 OAK ROAD, KEENWIK

10f. Zip Code

19975

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SALESPERSON

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

JOHN A. MASLIN, SR

18. Mother's Name (First, Middle, Maiden Surname)

MARY McNABB

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH M. LIGHT (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 OAK ROAD, KEENWIK, SELBYVILLE, DE 19975

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LAWN CROFT CEMETERY

Date

12/18/99

20c. Location - City or Town, State

LINWOOD, PENNSYLVANIA

21. Signature of Funeral Service Licensee

MO0866

22. Name and Address of Facility

PARSELL FUNERAL HOMES & CREMATORIUM INC.
1449 KINGS HIGHWAY, LEWES, DE 19958Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarct

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia

High Blood Pressure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

12/15/99

30. Name and address of person who completed cause of death (Item 25a) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD. 21811

410-641-4400

State
Registrar

31. Date filed (Month, Day, Year)

DEC 17 1999

32. Registrar's Signature

B. Sparks

HEAPS, GERTRUDE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

TIFFANI MARIE HAYMAN

2. Date of Death

Month Day Year
DECEMBER 29 1999

3. Time of Death

12:30 A

4a. Facility Name (If not Institution, give street and number)

ROUTE# 404 & WATTS CREEK BRIDGE

4b. City, Town, or Location of Death

DENTON

4c. County of Death

CAROLINE

Funeral
Director

5. Social Security Number

216-88-0810

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

26 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 1, 1973

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CAROLINE

10c. City, Town or Location

RIDGELY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

208 ORIOLE AVENUE

10f. Zip Code

21660

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12College (1-4 or 5+)
-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WAYNE WILSON WHEELER

18. Mother's Name (First, Middle, Maiden Summa)

VIVIAN LEE ADAMS

19a. Informant's Name/Relationship (Type, Print)

DONALD G. HAYMAN, JR./HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

208 ORIOLE AVENUE RIDGELY, MD. 21660

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN MEMORIAL PARK

Date

1-5-00

20c. Location - City or Town, State

EASTON, MD. 21601

21. Signature of Funeral Service Licensee

M. E. Newnam TO C.F.S.P.

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME
200 S. HARRISON ST. EASTON, MD. 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

12-28-99

28b. Time of Injury

2356 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Passenger in motor vehicle accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Watts Creek Bridge on Route 404

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Route 404 Caroline County, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

DECEMBER 29, 1999

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42772

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Beatrice Jones

2. Date of Death

December 11, 1999

3. Time of Death

1826

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

266-90-7700

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-2-35

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

707 East Road

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

4th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

laborer

16b. Kind of Business/Industry

domestic

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Bert Jones

19a. Informant's Name/Relationship (Type, Print)

Terry Jones/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ECI- Revells' Neck RD and US 13 Westover, MD 21871

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

12/20/99

20c. Location - City or Town, State

Salisbury, Maryland

21. Signature of Funeral Service Licensee

Patricia A. Jolley

22. Name and Address of Facility

1213 Jersey Road - Salisbury, Maryland 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Ds.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Hypercholesterolemia

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Prior to 1986

Prior to 1986

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert J. Kelly MD

29c. License number

D24986

29d. Date signed (Month, Day, Year)

12/13/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. Kelly MD 560 Riverside Dr. Salisbury Md. 21801

31. Date filed (Month, Day, Year)

DEC 17 1999

32. Registrar's Signature

Benjamin G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

99-7846-011

RANDOLPH H. JOHNSON

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42773

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician
/Medical
ExaminerFuneral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Randolph Henry Johnson, Jr.		2. Date of Death Month Day Year DECEMBER 29 1999		3. Time of Death 12:30 A	
4a. Facility Name (If not institution, give street and number) ROUTE# 404 & WATTS CREEK BRIDGE		4b. City, Town, or Location of Death DENTON		4c. County of Death CAROLINE	
5. Social Security Number 251 44 6951	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8/12/46
9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent			
10a. State Md.	10b. County Caroline	10c. City, Town or Location 8317 Denton Rd. Denton, Md.		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 8317 Denton Rd.		10f. Zip Code 21629		10g. Citizen of What Country? U.S.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 12/21/65		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver	
16b. Kind of Business/Industry LABOR		17. Father's Name (First, Middle, Last) Randolph H. Johnson Sr.		18. Mother's Name (First, Middle, Maiden Surname) Sadie Evans Johnson	
19a. Informant's Name/Relationship (Type, Print) Randolph H. Johnson Sr.		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8317 Denton Rd. Denton Md. 21629			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Md. Veterans Cem		20c. Location - City or Town, State Beluh Maryland	
21. Signature of Funeral Service Licensee Eric L. Dashiell		22. Name and Address of Facility Eric L. Dashiell, F.S. 322 East Ave. Easton Maryland 21601			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 12-28-99		28b. Time of Injury 2356 M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Motor vehicle accident			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Watts Creek Bridge on route 404		28f. Location (Street and Number or Rural Route Number, City or Town, State) Caroline County, Maryland			
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Stephen S. Radentz, M.D.		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) DECEMBER 29, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature G. Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42774

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

EVA VIRGINIA LISTER

2. Date of Death

Month

Day

Year

Dec

31

1999

3. Time of Death

0816

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Easton, Md

4c. County of Death

Talbot

Funeral
Director

5. Social Security Number

218-20-8967

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month

Day

Year

AUG. 18,

1926

9. Birthplace (State or Foreign

Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

22 JUDAS STREET

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14-0r 5+)

-0-

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

MEDICAL

17. Father's Name (First, Middle, Last)

OTTO H. KAUFMAN

18. Mother's Name (First, Middle, Maiden Surname)

MARTHA EDNA PATCHETT

19a. Informant's Name/Relationship (Type, Print)

J. PAUL LISTER / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

22 JUDAS ST. EASTON, MD. 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

DENTON CEMETERY

Date

1-4-00

20c. Location - City or Town, State

DENTON, MD.

21. Signature of Funeral Service Licensee

M. E. Newnam III CFSP

22. Name and Address of Facility

FELLOWS, HELFENBEIN AND NEWMAN FUNERAL HOME, P.A.
200 S. HARRISON ST., EASTON, MD. 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardio pulmonary arrest

Due to (or as a consequence of):

b. Acute Myocardial infarction

Due to (or as a consequence of):

c. Arteriosclerotic Heart Disease

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Minutes

Minutes

30g

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes Mellitus II

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

William H. Wood Jr.

29c. License number

1708715

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

WILLIAM H. WOOD, JR., M.D. 506 IDLEWILD AVE. EASTON, MD. 21601

31. Date filed (Month, Day, Year)

JAN 03 2000

32. Registrar's Signature

B. Sparks

State
RegistrarBaltimore, Maryland 21215-0020
Eva Lister
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42775

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) KERMIT M. MADDOX				2. Date of Death Month Day Year December 09 1999		3. Time of Death 10:00AM.	
	4e. Facility Name (If not institution, give street and number) 8575 Old Westover Marion Road				4b. City, Town, or Location of Death Westover		4c. County of Death Somerset	
Funeral Director	5. Social Security Number 219-01-9112		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 28, 1909	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Somerset		10c. City, Town or Location Westover	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 7585 Old Westover/Marion Road			
	10f. Zip Code 21871				10g. Citizen of What Country? USA			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) +4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) self-employed interior/exterior decorator & bus contractor		16b. Kind of Business/Industry Somerset County			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Artie Maddox				18. Mother's Name (First, Middle, Maiden Surname) Rosena Collins			
	19a. Informant's Name/Relationship (Type, Print) Michael Ballard/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6534 Afterglow Lane - Indian Trail, NC 28079			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) John Wesley Cemetery		20c. Location - City or Town, State Princess Anne, MD		20d. Date 12/16/99	
	21. Signature of Funeral Service Licensee Loretta B. Jolley				22. Name and Address of Facility JOLLEY MEMORIAL CHAPEL 1213 Jersey Road - Salisbury, MD			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive and Arteriosclerotic Due to (or as a consequence of): b. Cardiovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? Inspection 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. Signature and title of certifier J. Pustan, M.D.
	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) December 10, 1999					
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201							31. Date filed (Month, Day, Year) DEC 15 1999
	32. Registrar's Signature B. Sparks							

1944-1945

1944-1945

1944-1945

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42776

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

William Moore

2. Date of Death

Month

Day

3. Time of Death

December 24, 1999

0558

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

220-30-1860

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Jan 11, 1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Hebron

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

104 Elm Street

10f. Zip Code

21830

10g. Citizen of What Country?

U.S.

11. Marital Status

☐ Never Married ☒ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Jack Driver

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

William E. Moore, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Emma Moore

19a. Informant's Name/Relationship (Type, Print)

Rosalee Moore/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 24, Hebron, MD 21830

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Acres Mem Park

Date

12/29/99

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 21801Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Lung Cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 yr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☒ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation
☐ Accident ☐ Could not be determined
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Nagel

29c. License number

D22160

29d. Date signed (Month, Day, Year)

12-24-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William J Nagel, MD

Peninsula Regional Med Ctr Salisbury

State
Registrar

31. Date filed (Month, Day, Year)

DEC 28 1999

32. Registrar's Signature

B. Sparks

ORIGINAL

William Moore SS# 220-30-1860

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

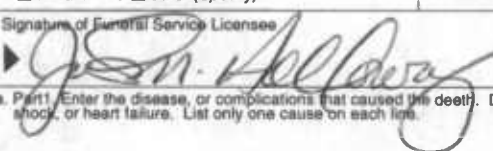
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42777

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT RICHMOND MEALY				2. Date of Death Month December Day 23 Year 1999				3. Time of Death 0415	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 212-10-4281		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	Usual Residence of Decedent		8. Date of Birth (Month, Day, Year) June 4, 1914		9. Birthplace (State or Foreign Country) Maryland					
To Be Completed by Funeral Director	10a. State Maryland		10b. County Worcester		10c. City, Town or Location Bishopville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 10931 Piney Island Dr.				10f. Zip Code 21813		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) I				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman			16b. Kind of Business/Industry Automotive Fabrics		
	17. Father's Name (First, Middle, Last) Guy Mealy				18. Mother's Name (First, Middle, Maiden Surname) Laura Richmond					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ednell Mae Mealy/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10931 Piney Island Dr., Bishopville, MD 21813					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park		Date 12/27/99		20c. Location - City or Town, State Salisbury, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. chronic obstructive pulmonary disease Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. chronic Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. hypertension, pneumonia								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier 				29c. License number D30853		29d. Date signed (Month, Day, Year) 12/23/99			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles B. Silva Jr MD PRMC Salisbury MD 21801									
State Registrar	31. Date filed (Month, Day, Year) DEC 23 1999		32. Registrar's Signature 							

1944

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

39 42778

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN A LONZA MALONE				2. Date of Death Month Day Year December 21, 1999		3. Time of Death 2:05 PM		
	4a. Facility Name (If not institution, give street and number) 1014 Schumaker Woods Rd.				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 215-20-1274	8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) November 5, 1926		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico		10c. City, Town or Location Salisbury			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10a. Street and Number 1014 Schumaker Woods Rd.			10f. Zip Code 21804		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Navy If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Architect		16b. Kind of Business/Industry Architecture			
	17. Father's Name (First, Middle, Last) William Twilley Malone				18. Mother's Name (First, Middle, Maiden Surname) Beatrice Jones				
	19a. Informant's Name/Relationship (Type, Print) Bettie Sue Malone/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Schumaker Woods Rd., Salisbury, MD 21804				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Allen Cemetery		Date 12/24/99		20c. Location - City or Town, State Allen, MD		
	21. Signature of Funeral Service Licensee David A. Thompson MO1051				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Myeloma Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 yrs								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier				29c. License number D26278		29d. Date signed (Month, Day, Year) 12-22-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Connell, MD 145E Carroll St. Salisbury, MD 21801									
31. Date filed (Month, Day, Year) DEC 23 1999		32. Registrar's Signature Benjamin A. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

1. ~~Abno~~ A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42779

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLET MILLS

2. Date of Death
Month Day Year
December 18, 19993. Time of Death
0540

4a. Facility Name (If not Institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

215-16-8701

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

OCT. 4, 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

FRUITLAND

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

631 CLYDE AVE.

10f. Zip Code

21826

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
11

Collega (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

RETAIL STORE

17. Father's Name (First, Middle, Last)

VERNON EDWARD KILLIAM

18. Mother's Name (First, Middle, Maiden Surname)

M. GWENDOLYN HARRISON

19a. Informant's Name/Relationship (Type, Print)

WILLIAM K. MILLS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

631 CLYDE AVE. FRUITLAND, MD 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HEBRON CEMETERY

Date

12-20-99

20c. Location - City or Town, State

HEBRON, MARYLAND

21. Signature of Funeral Service Licensee

B. Reith, Physician, CFSP

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO RESPIRATORY ARREST

Due to (or as a consequence of):

IMMEDIATE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEVERE HYPOXIA

Due to (or as a consequence of):

3 DAYS

c. (C) SIDE LOBAR PNEUMONIA

Due to (or as a consequence of):

1 WEEK

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRO VASCULAR ACCIDENT

HYPERTENSION HEART FAILURE

GLAUCOMA ARTHRITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide5 ☐ Pending Investigation
6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Physician2 ☐ Medical ExaminerCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MOHAN BHAT, MD

29c. License number

DOO55006

29d. Date signed (Month, Day, Year)

DECEMBER 18, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614-B EASTERN SHORE DRIVE, SALISBURY, MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

DEC 20 1999

32. Registrar's Signature

S. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42780

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN FLORENCE MASSEY						2. Date of Death Month Day Year DECEMBER 15, 1999		3. Time of Death 6:15 P.M.	
	4a. Facility Name (If not institution, give street and number) BERLIN NURSING HOME						4b. City, Town, or Location of Death BERLIN		4c. County of Death WORCESTER	
Funeral Director	5. Social Security Number 218-48-5731		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) JULY 20, 1916		9. Birthplace (State or Foreign Country) DELAWARE	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location WILLARDS				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 6601 BENT PINE RD.				10f. Zip Code 21874		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) POULTRY FARMER			16b. Kind of Business/Industry OWN FARM			
17. Father's Name (First, Middle, Last) ABE LAYTON						18. Mother's Name (First, Middle, Maiden Surname) FLORENCE CALHOUN				
19a. Informant's Name/Relationship (Type, Print) CONNIE E. MASSEY - DAUGHTER IN-LAW						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6773 BENT PINE RD. WILLARDS, MD 21874				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY		Date 12/16/99		20c. Location - City or Town, State CAMBRIDGE, MARYLAND			
21. Signature of Funeral Service Licensee B. Keitt			22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804			705 E. MAIN ST.				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Acute Myocardial Infarct hours</u> Due to (or as a consequence of): b. <u>Coronary Artery Disease years</u> Due to (or as a consequence of): c. <u>Arteriosclerosis</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Recent + Old Cerebro Vascular</u> <u>Senility</u> <u>Accident.</u>										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier F. Arthes			29c. License number D02026		29d. Date signed (Month, Day, Year) 12-16-99		
30. Name and address of person who completed cause of death (from 23a) (Type, Print) DR. FEDERICO ARTHES, MD 46 TEAL DR., BERLIN, MD. 21811 410-641-4400										
31. Date filed (Month, Day, Year) DEC 17 1999			32. Registrar's Signature S. Sparks							

MASSEY, HELEN

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42781

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

William Markel Miles

2. Date of Death

Month Day Year
DECEMBER 31 1999

3. Time of Death

02:52AM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
Dec. 26, 1999

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

319 Chesapeake Ave.

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify:

Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Infant

16b. Kind of Business/Industry

Infant

17. Father's Name (First, Middle, Last)

William Green, Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Tyshonna Miles

19a. Informant's Name/Relationship (Type, Print)

Tyshonna Miles, mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

319 Chesapeake Ave., Crisfield, Maryland 21817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Mt. Piere Cemetery

Date

1/8/2000

20c. Location - City or Town, State

Marion, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bennie Smith Funeral Home

P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Respiratory Distress Syndrome

Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

5 days

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) Last

b. Prematurity

Due to (or as a consequence of):

5 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Henry C Baggett

29c. License number

RES-00

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Henry C Baggett 1114 William Street Baltimore, MD 21230

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

Shirley G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 25a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
202-358-2000.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended # 2 / 12/16/99/ WCHD/ HLC

Reg. No. 99 42782

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Louise Polson

2. Date of Death

Month 12 Day 13 Year 99

3. Time of Death

1:30 pm

4a. Facility Name (If not institution, give street end number)

608 Morris Street

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

163-28-3840

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 4 1934

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

608 Morris Street

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Beauty Salon

17. Father's Name (First, Middle, Last)

Robert White

18. Mother's Name (First, Middle, Maiden Surname)

Alene Felton

19a. Informant's Name/Relationship (Type, Print)

Parthenia White (Sister)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

53 Harry S. Turman DR. Apt. 22 Largo, Md. 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Springhill Mem. Garden

Date

12/16/99

20c. Location - City or Town, State

Hebron, Md.

21. Signature of Funeral Service Licensee

► Gladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home

821 West Rd. Salisbury, Md. 21801

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

e. Cardiac arrest

Due to (or as a consequence of):

b. end-stage kidney disease

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death1 year
1 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

end-stage kidney disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

► Cynthia J. Tan M.D.

29c. License number

MD 16725

29d. Date signed (Month, Day, Year)

12/16/99

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TAN, CONSTANCE 547-G Riverside Dr. Salisbury MD 21801

31. Date filed (Month, Day, Year)

DEC 16 1999

32. Registrar's Signature

A. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42783

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLADYS E. PHILLIPS				2. Date of Death Month Day Year December 29 1999		3. Time of Death 0917
	4a. Facility Name (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 214-10-9609	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 27, 1908	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent						
10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 306 CAREY AVE.				10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME	
17. Father's Name (First, Middle, Last) DAVID D. SHORT				18. Mother's Name (First, Middle, Maiden Surname) MARGARET E. ESHAM			
19a. Informant's Name/Relationship (Type, Print) GRAND JENNIFER L. FRIEMAN - DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 S. DIVISION ST. SALISBURY, MD 21804			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) PARSONS CEMETERY		Date 1/3/2000		20c. Location - City or Town, State SALISBURY, MARYLAND	
21. Signature of Funeral Service Licensee B. Keet		22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular disease Due to (or as a consequence of): b. HTN Due to (or as a consequence of): c. Congestive heart failure Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier [Signature]		29c. License number D5004127		29d. Date signed (Month, Day, Year) 12/29/99			
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Dr. ALON DAVIS 3 BISTATE Blvd Delmar, MD 21875							
31. Date filed (Month, Day, Year) JAN 03 2000		32. Registrar's Signature [Signature]					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42784

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN C. PROVOST, SR.				2. Date of Death Month Day Year DEC. 23 1999		3. Time of Death 6:50 PM	
	4a. Facility Name (If not institution, give street and number) 1310 HAMILTON ST.				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 216-38-7982		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) JAN. 21, 1941	
	9. Birthplace (State or Foreign Country) NEW YORK		10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1310 HAMILTON ST.		10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: MARINE CORPS.		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TECHNICIAN		16b. Kind of Business/Industry PHONE COMPANY		17. Father's Name (First, Middle, Last) CLARENCE J. PROVOST	
	18. Mother's Name (First, Middle, Maiden Surname) BEATRICE M. VALLIERE		19a. Informant's Name/Relationship (Type, Print) KAREN E. PROVOST - WIFE		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 HAMILTON ST. SALISBURY, MD 21804		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) OLD MARDELA CEMETERY		20c. Location - City or Town, State MARDELA SPRINGS, MD		21. Signature of Funeral Service Licensee B. Keet P. Hyman, CFSP		22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Carcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier B. Keet P. Hyman		29c. License number D36576		29d. Date signed (Month, Day, Year) 12/27/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RONALD P. TRAYITE 560 RIVERSIDE DR, SALISBURY MD 21801	
	31. Date filed (Month, Day, Year) DEC 27 1999		32. Registrar's Signature P. Sparks		33. Registrar's Title Registrar		34. Registrar's Name P. Sparks	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42785

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Robert MAURICE Polk. SR

2. Date of Death

December 16, 1999 1130

3. Time of Death

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

213-14-6336

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-12-21

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

md

10b. County

Somerset

10c. City, Town or Location

Eden

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3830 S. upper Ferry Rd.

10f. Zip Code

21822

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

276 AMERICAN

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

County

17. Father's Name (First, Middle, Last)

James HEALWA

18. Mother's Name (First, Middle, Maiden Surname)

Dorinda THICK

19e. Informant's Name/Relationship (Type, Print)

Madelina Polk wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3830 S. upper Ferry Rd. Eden md.

20e. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

friendship ch. care

Date

12/22/99

20c. Location - City or Town, State

Allen md.

21. Signature of Funeral Service Licensee

John A. Prince

22. Name and Address of Facility

BENNIE SMITH F/H
917 W. ISABELLE ST. SALISBURY MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Asystole

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Aspiration pneumonia

Due to (or as a consequence of):

c. pulmonary edema

Due to (or as a consequence of):

d. Abdominal ileus

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles L. Rankin

29c. License number

D19289

29d. Date signed (Month, Day, Year)

12-17-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles L. Rankin 400 Eastern St. Dr. Salisbury, md. 21801

31. Date filed (Month, Day, Year)

DEC 21 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Robert Polk

Baltimore, Maryland 21215-0020

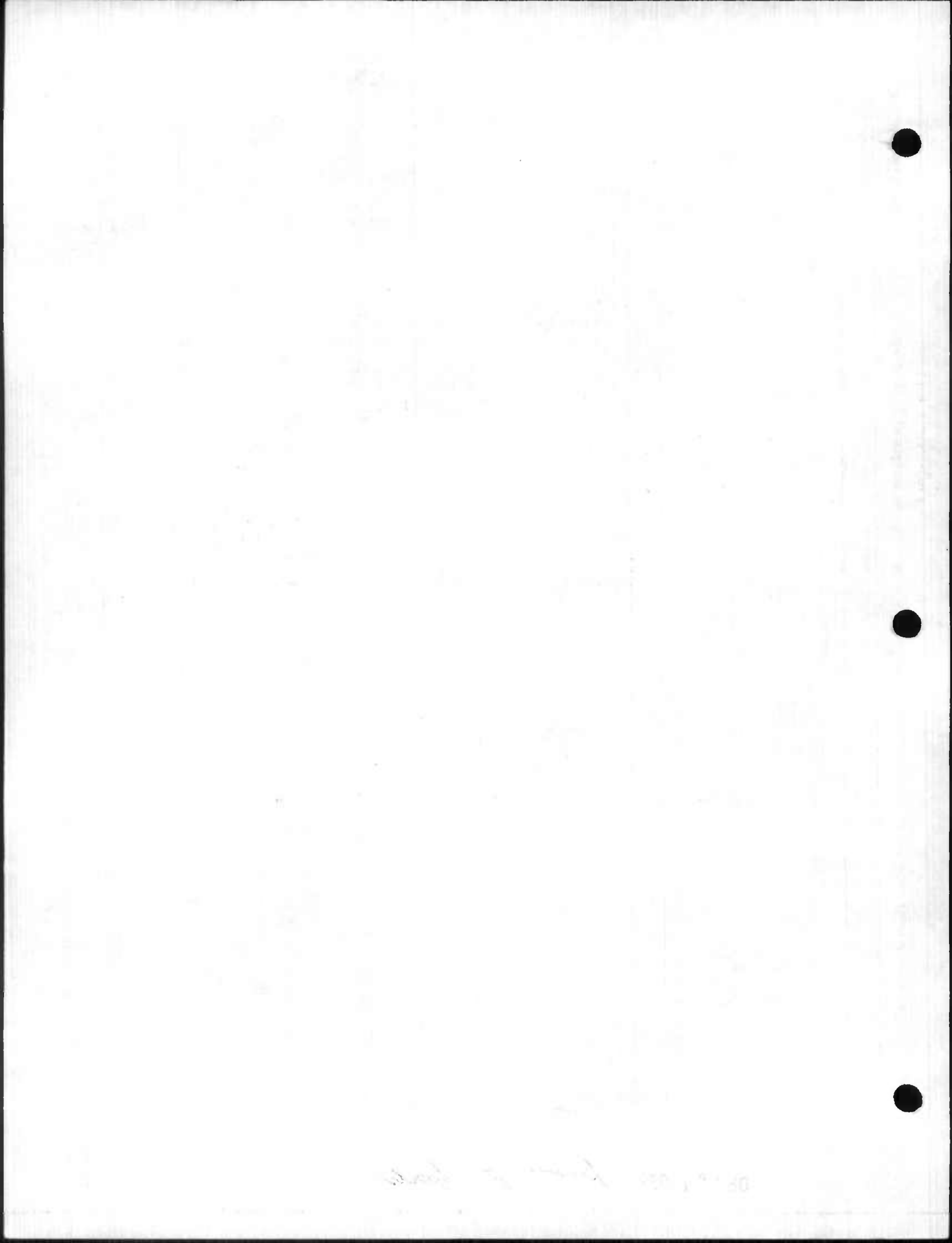
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended #26/12-21-99/WCHD/HLC

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Shelton Brooks Seldon Jr.				2. Date of Death Month Dec. Day 16 Year 1999		3. Time of Death 1:05 PM	
4a. Facility Name (If not institution, give street and number) 835 Chippewa Blvd.				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
5. Social Security Number 218-40-5539		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 18 1941	
9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 835 Chippewa Blvd.		10f. Zip Code 21801		10g. Citizen of What Country? U.S.A	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry None		17. Father's Name (First, Middle, Last) Shelton Brooks Seldon SR.	
18. Mother's Name (First, Middle, Maiden Surname) Beulah Moore		19a. Informant's Name/Relationship (Type, Print) Melvin Seldon (Brother)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 835 Chippewa Blvd. Salisbury, Md. 21801		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Friendship UM Church		20c. Location - City or Town, State Quantico, Md.		21. Signature of Funeral Service Licensee Bladys B. Stewart		22. Name and Address of Facility Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 7 MON.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier R. H. Hall, M.D.		29c. License number 029168		29d. Date signed (Month, Day, Year) 12/21/99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Power St. Salisbury Md. 21804	
31. Date filed (Month, Day, Year) DEC 21 1999		32. Registrar's Signature B. Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42787

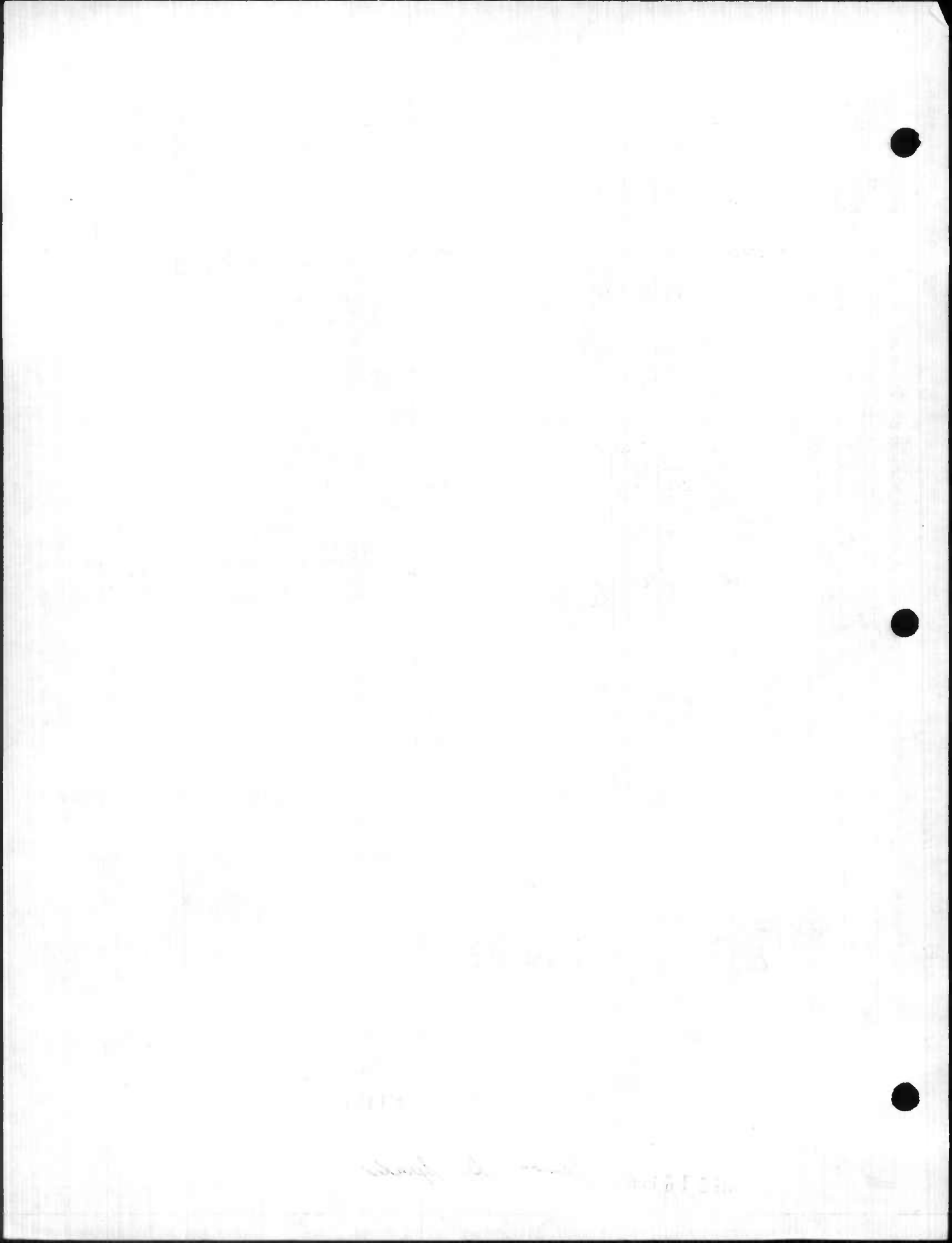
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOROTHA STURGIS TILGHMAN				2. Date of Death Month Day Year December 13, 1999		3. Time of Death 1218	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 214-18-4682		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) May 21, 1909	
	10a. State Maryland		10b. County Wicomico		10c. City, Town or Location salisbury		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
Usual Residence of Decedent								
10e. Street and Number 2712 Merritt Mill Rd.				10f. Zip Code 21804		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) -			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Insurance		
17. Father's Name (First, Middle, Last) Lloyd William Sturgis				18. Mother's Name (First, Middle, Maiden Surname) Anna Elizabeth Adams				
19a. Informant's Name/Relationship (Type, Print) Daniel A. Tilghman/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2712 Merritt Mill Rd., Salisbury, MD 21804				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Wicomico Memorial Park		Date 12/17/99		20c. Location - City or Town, State Salisbury, MD	
21. Signature of Funeral Service Licensee Kelt R. Dewey				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute Myo. wall MI Due to (or as a consequence of): CAD Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. Atherosclerosis Due to (or as a consequence of): g. Due to (or as a consequence of): h.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Bal Agarwal MD				29c. License number 17181		29d. Date signed (Month, Day, Year) 12/13/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bal Agarwal 614C Eastern Shore Dr. Salisbury md.								
31. Date filed (Month, Day, Year) DEC 16 1999			32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

State Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

89 42788

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician / Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) OLIN JAMES TARR, SR.				2. Date of Death Month Day Year DEC. 13 1999		3. Time of Death 3:00 AM	
4a. Facility Name (If not institution, give street and number) 605 SCHUMAKER LANE				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
5. Social Security Number 220-16-9785		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 5, 1924	
9. Birthplace (State or Foreign Country) MARYLAND							
Usual Residence of Decedent							
10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 605 SCHUMAKER LANE				10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MAINTENANCE		16b. Kind of Business/Industry CITY OF SALISBURY	
17. Father's Name (First, Middle, Last) ERNEST M. TARR				18. Mother's Name (First, Middle, Maiden Surname) CLARA TOWNSEND			
19a. Informant's Name/Relationship (Type, Print) NAOMI R. TARR - WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 SCHUMAKER LANE SALISBURY, MD 21804			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MD. EASTERN SHORE VA CEM		Date 12/16/99		20c. Location - City or Town, State HURLOCK, MARYLAND	
21. Signature of Funeral Service Licensee B. Keith Phyllis, CFSP				22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. acute Respiratory failure due to Due to (or as a consequence of): Bronchopneumonia - Disrupted mobility Due to (or as a consequence of): old lacunar infarct Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. v. w. x. y. z. aa. ab. ac. ad. ae. af. ag. ah. ai. aj. ak. al. am. an. ao. ap. aq. ar. as. at. au. av. aw. ax. ay. az. ba. bb. bc. bd. be. bf. bg. bh. bi. bj. bk. bl. bm. bn. bo. bp. bq. br. bs. bt. bu. bv. bw. bx. by. bz. ca. cb. cc. cd. ce. cf. cg. ch. ci. cj. ck. cl. cm. cn. co. cp. cq. cr. cs. ct. cu. cv. cw. cx. cy. cz. da. db. dc. dd. de. df. dg. dh. di. dj. dk. dl. dm. dn. do. dp. dq. dr. ds. dt. du. dv. dw. dx. dy. dz. ea. eb. ec. ed. ee. ef. eg. eh. ei. ej. ek. el. em. en. eo. ep. eq. er. es. et. eu. ev. ew. ex. ey. ez. fa. fb. fc. fd. fe. ff. fg. fh. fi. fj. fk. fl. fm. fn. fo. fp. fq. fr. fs. ft. fu. fv. fw. fx. fy. fz. ga. gb. gc. gd. ge. gf. gg. gh. gi. gj. gk. gl. gm. gn. go. gp. gq. gr. gs. gt. gu. gv. gw. gx. gy. gz. ha. hb. hc. hd. he. hf. hg. hh. hi. hj. hk. hl. hm. hn. ho. hp. hq. hr. hs. ht. hu. hv. hw. hx. hy. hz. ia. ib. ic. id. ie. if. ig. ih. ii. ij. ik. il. im. in. io. ip. iq. ir. is. it. iu. iv. iw. ix. iy. iz. ja. jb. jc. jd. je. jf. jg. jh. ji. jj. jk. jl. jm. jn. jo. jp. jq. jr. js. jt. ju. jv. jw. jx. jy. jz. ka. kb. kc. kd. ke. kf. kg. kh. ki. kj. kl. km. kn. ko. kp. kq. kr. ks. kt. ku. kv. kw. kx. ky. kz. la. lb. lc. ld. le. lf. lg. lh. li. lj. lk. ll. lm. ln. lo. lp. lq. lr. ls. lt. lu. lv. lw. lx. ly. lz. ma. mb. mc. md. me. mf. mg. mh. mi. mj. mk. ml. mm. mn. mo. mp. mq. mr. ms. mt. mu. mv. mw. mx. my. mz. na. nb. nc. nd. ne. nf. ng. nh. ni. nj. nk. nl. nm. nn. no. np. nq. nr. ns. nt. nu. nv. nw. nx. ny. nz. oa. ob. oc. od. oe. of. og. oh. oi. oj. ok. ol. om. on. oo. op. oq. or. os. ot. ou. ov. ow. ox. oy. oz. pa. pb. pc. pd. pe. pf. pg. ph. pi. pj. pk. pl. pm. pn. po. pp. pq. pr. ps. pt. pu. pv. pw. px. py. pz. qa. qb. qc. qd. qe. qf. qg. qh. qi. qj. qk. ql. qm. qn. qo. qp. qq. qr. qs. qt. qu. qv. qw. qx. qy. qz. ra. rb. rc. rd. re. rf. rg. rh. ri. rj. rk. rl. rm. rn. ro. rp. rq. rr. rs. rt. ru. rv. rw. rx. ry. rz. sa. sb. sc. sd. se. sf. sg. sh. si. sj. sk. sl. sm. sn. so. sp. sq. sr. ss. st. su. sv. sw. sx. sy. sz. ta. tb. tc. td. te. tf. tg. th. ti. tj. tk. tl. tm. tn. to. tp. tq. tr. ts. tu. tv. tw. tx. ty. tz. ua. ub. uc. ud. ue. uf. ug. uh. ui. uj. uk. ul. um. un. uo. up. uq. ur. us. ut. uu. uv. uw. ux. uy. uz. va. vb. vc. vd. ve. vf. vg. vh. vi. vj. vk. vl. vm. vn. vo. vp. vq. vr. vs. vt. vu. vv. vw. vx. vy. vz. wa. wb. wc. wd. we. wf. wg. wh. wi. wj. wk. wl. wm. wn. wo. wp. wq. wr. ws. wt. wu. wv. ww. wx. wy. wz. xa. xb. xc. xd. xe. xf. xg. xh. xi. xj. xk. xl. xm. xn. xo. xp. xq. xr. xs. xt. xu. xv. xw. xx. xy. xz. ya. yb. yc. yd. ye. yf. yg. yh. yi. yj. yk. yl. ym. yn. yo. yp. yq. yr. ys. yt. yu. yv. yw. yx. yy. yz. za. zb. zc. zd. ze. zf. zg. zh. zi. zj. zk. zl. zm. zn. zo. zp. zq. zr. zs. zt. zu. zv. zw. zx. zy. zz.						Approximate Interval Between Onset and Death 6 hr 20 yrs. 5 yrs.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. Z. Badros, MD		29c. License number D15192		29d. Date signed (Month, Day, Year) 12/15/99	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph Z. Badros 813 B Eastern Shore Drive Salisbury, MD 21804							
31. Date filed (Month, Day, Year) DEC 16 1999				32. Registrar's Signature B. Sparks			

4
1/4

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42789

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Stevenson Thomas				2. Date of Death Month Dec. Day 24 Year 1999		3. Time of Death 8:15 PM	
	4a. Facility Name (If not institution, give street and number) Salisbury Center; Genesis ElderCare				4b. City, Town, or Location of Death Salisbury, Md.		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 082-16-1063	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Month Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 2, 1913		9. Birthplace (State or Foreign Country) VIRGINIA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County WICOMICO	10c. City, Town or Location SALISBURY			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number 27486 RIVERSIDE DR. EXT.			10f. Zip Code 21801		10g. Citizen of What Country? U.S.A.		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MARINE ENGINEER		16b. Kind of Business/Industry FISH PRODUCTS			
	17. Father's Name (First, Middle, Last) HARRY H. THOMAS				18. Mother's Name (First, Middle, Maiden Surname) MATILDA F. PRUITT			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JOAN M. JENKINS - DAUGHTER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10935 HARRY RIGGIN RD. PRINCESS ANNE, MD 21853				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) WICOMICO MEMORIAL PARK		20c. Location - City or Town, State 12/29/99 SALISBURY, MARYLAND		20d. Date	
	21. Signature of Funeral Service Licensee <i>B. Keitt</i>			22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Emphysema AND Aneurysm Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHF Renal insufficiency							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>			29c. License number D-39813		29d. Date signed (Month, Day, Year) 12/27/99		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD. 21804							
31. Date filed (Month, Day, Year) DEC 27 1999 Registrar's Signature: <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10/10/19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42790

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ralph G. Tingle

2. Date of Death

Month
DecDay
17Year
1999

3. Time of Death

1:10 p.m.

4a. Facility Name (If not institution, give street and number)

Deer's Head Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral
Director

5. Social Security Number

217-07-5883

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

3/31/1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Pittsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RFD Tingle Road

10f. Zip Code

21850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

owner & carpenter

16b. Kind of Business/Industry

general store

17. Father's Name (First, Middle, Last)

James H. Tingle

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Bell Truitt

19a. Informant's Name/Relationship (Type, Print)

Richard L. Marshall (nephew)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27569 Pemberton Dr., Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Line Methodist Cemetery

Date

12/20/99 Whitesville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David G. Thompson

22. Name and Address of Facility

Holloway Funeral Home, P.A.

501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

13 days

b. Dehydration
Due to (or as a consequence of):

13 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Chronic obstructive pulmonary disease
Due to (or as a consequence of):

several years

d. Angina Pectoris
Due to (or as a consequence of):

several years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

senile dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. J. Howard

29c. License number

D16003

29d. Date signed (Month, Day, Year)

Dec 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INJA J HUANG, M.D. P.O. Box 2018, Salisbury, MD 21801

31. Date filed (Month, Day, Year)

DEC 20 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

99 4279

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42792

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH V. WILSON

2. Date of Death

December 14, 1999

3. Time of Death

0110

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

212-18-6936

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
AUG. 2, 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

MARDELA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25761 OCEAN GATEWAY

10f. Zip Code

21837

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

COOK

16b. Kind of Business/Industry

SCHOOL CAFETERIA

17. Father's Name (First, Middle, Last)

KENT DYKES

18. Mother's Name (First, Middle, Maiden Surname)

ETHEL DYKES

19a. Informant's Name/Relationship (Type, Print)

STANFORD L. WILSON - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25761 OCEAN GATEWAY MARDELA SPRINGS, MD 21837

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARDELA MEMORIAL CEMETERY 12/18/99 MARDELA SPRINGS, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

B. Keitt P. Hyman, CFS

22. Name and Address of Facility

705 E. MAIN ST.
BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia, probable acute MI

one hour

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DVT/PE SIP Greenfield center

CHF, HTN

Right Tibial Fracture

SIP Stroke

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. Keitt P. Hyman, CFS

29c. License number

37813

29d. Date signed (Month, Day, Year)

12/16/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARXINS MD SCGE, RT 50 + E. CIVIL AVE SALISBURY MD 21804

State
Registrar

31. Date filed (Month, Day, Year)

DEC 16 1999

Registrar's Signature

B. Keitt P. Hyman, CFS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42793

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mabel Waters

2. Date of Death

Dec. 21 1999

3. Time of Death

6:AM

4a. Facility Name (If not institution, give street and number)

Tawes Nursing Home

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral
Director

5. Social Security Number

213-14-7062

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 23 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

316 Locust Street

10f. Zip Code

21817

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Jeffrey White

18. Mother's Name (First, Middle, Maiden Surname)

Milkie Anderson

19a. Informant's Name/Relationship (Type, Print)

Jeffery Waters (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

27105 Crisfield Marion Rd. Crisfield, Md. 21817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

John Wesley Cemetery

Date

12/27/99

20c. Location - City or Town, State

Marion, Md.

21. Signature of Funeral Service Licensee

Gladys B. Stewart

22. Name and Address of Facility

Stewart Funeral Home
821 West Rd. Salisbury, Md. 2180123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a.

Due to (or as a consequence of):

Aspiration Pneumonia

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Vijay Karumbunathan

29c. License number

D48098

29d. Date signed (Month, Day, Year)

12/21/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vijay Karumbunathan, 201 Hall Highway Crisfield Md. 21817

31. Date filed (Month, Day, Year)

DEC 23 1999

32. Registrar's Signature

B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G779 1-28 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Curtis Williams</i>				2. Date of Death Month Day Year December 07 1999		3. Time of Death 06:22 PM.	
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number <i>228-42-0896</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>67</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 8-3-32		9. Birthplace (State or Foreign Country) <i>VA</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>md.</i>	10b. County <i>Wicomico</i>	10c. City, Town or Location <i>Eden</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>4758 S upper fair Rd</i>			10f. Zip Code <i>21822</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>African American</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Welding</i>			16b. Kind of Business/Industry <i>Mantura Co</i>		
	17. Father's Name (First, Middle, Last) <i>John William</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Unknown</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Curtis Williams</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4758 upper fair Rd. Eden md. 21827</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Sparks Hill</i>		20c. Location - City or Town, State <i>Eden md.</i>		20d. Date <i>12/6/99</i>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>BROOK Smith B/A 517 W. Isabelle St Salisbury md.</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Wayne D. McKee</i>		29c. License number <i>O.C.M.E.</i>		29d. Date signed (Month, Day, Year) <i>December 12, 1999</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Wayne D. McKee 111 Penn Street, Baltimore, Maryland 21201</i>								
31. Date filed (Month, Day, Year) <i>DEC 21 1999</i>		32. Registrar's Signature <i>Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42795

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) JAMES LEROY WILLEY JR. 2. Date of Death Month Day Year DEC. 16 1999 3. Time of Death 11:15 PM

Funeral
Director

4a. Facility Name (If not institution, give street and number) ESHAM FARM, BACK CREEK ROAD 4b. City, Town, or Location of Death BISHOPVILLE 4c. County of Death WORCESTER

5. Social Security Number 222-24-8285 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 60 Yrs. 8. Date of Birth (Month, Day, Year) AUG. 18, 1939 9. Birthplace (State or Foreign Country) DELAWARE

Usual Residence of Decedent 10a. State MARYLAND 10b. County WORCESTER 10c. City, Town or Location BISHOPVILLE 10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 10207 HOTEL ROAD 10f. Zip Code 21813 10g. Citizen of What Country? USA

11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FARMER 16b. Kind of Business/Industry AGRICULTURE

17. Father's Name (First, Middle, Last) JAMES L. WILLEY SR. 18. Mother's Name (First, Middle, Maiden Surname) ALICE McGEE

19a. Informant's Name/Relationship (Type, Print) DONNA L. WILLEY/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10207 HOTEL ROAD, BISHOPVILLE, MARYLAND 21813

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) BISHOPVILLE CEMETERY 20c. Location - City or Town, State BISHOPVILLE, MARYLAND

21. Signature of Funeral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DELAWARE 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GUNSHOT WOUND TO HEAD 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

23c. Due to (or as a consequence of): 23d. Due to (or as a consequence of): 23e. Due to (or as a consequence of): 23f. Due to (or as a consequence of):

23g. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

23i. Were en autopsy performed? 1 Yes 2 No 23j. Were en autopsy performed? 1 Yes 2 No

23k. Were en autopsy performed? 1 Yes 2 No 23l. Were en autopsy performed? 1 Yes 2 No

23m. Were en autopsy performed? 1 Yes 2 No 23n. Were en autopsy performed? 1 Yes 2 No

23o. Were en autopsy performed? 1 Yes 2 No 23p. Were en autopsy performed? 1 Yes 2 No

23q. Were en autopsy performed? 1 Yes 2 No 23r. Were en autopsy performed? 1 Yes 2 No

23s. Were en autopsy performed? 1 Yes 2 No 23t. Were en autopsy performed? 1 Yes 2 No

23u. Were en autopsy performed? 1 Yes 2 No 23v. Were en autopsy performed? 1 Yes 2 No

23w. Were en autopsy performed? 1 Yes 2 No 23x. Were en autopsy performed? 1 Yes 2 No

23y. Were en autopsy performed? 1 Yes 2 No 23z. Were en autopsy performed? 1 Yes 2 No

23aa. Were en autopsy performed? 1 Yes 2 No 23ab. Were en autopsy performed? 1 Yes 2 No

23ac. Were en autopsy performed? 1 Yes 2 No 23ad. Were en autopsy performed? 1 Yes 2 No

23ae. Were en autopsy performed? 1 Yes 2 No 23af. Were en autopsy performed? 1 Yes 2 No

23ag. Were en autopsy performed? 1 Yes 2 No 23ah. Were en autopsy performed? 1 Yes 2 No

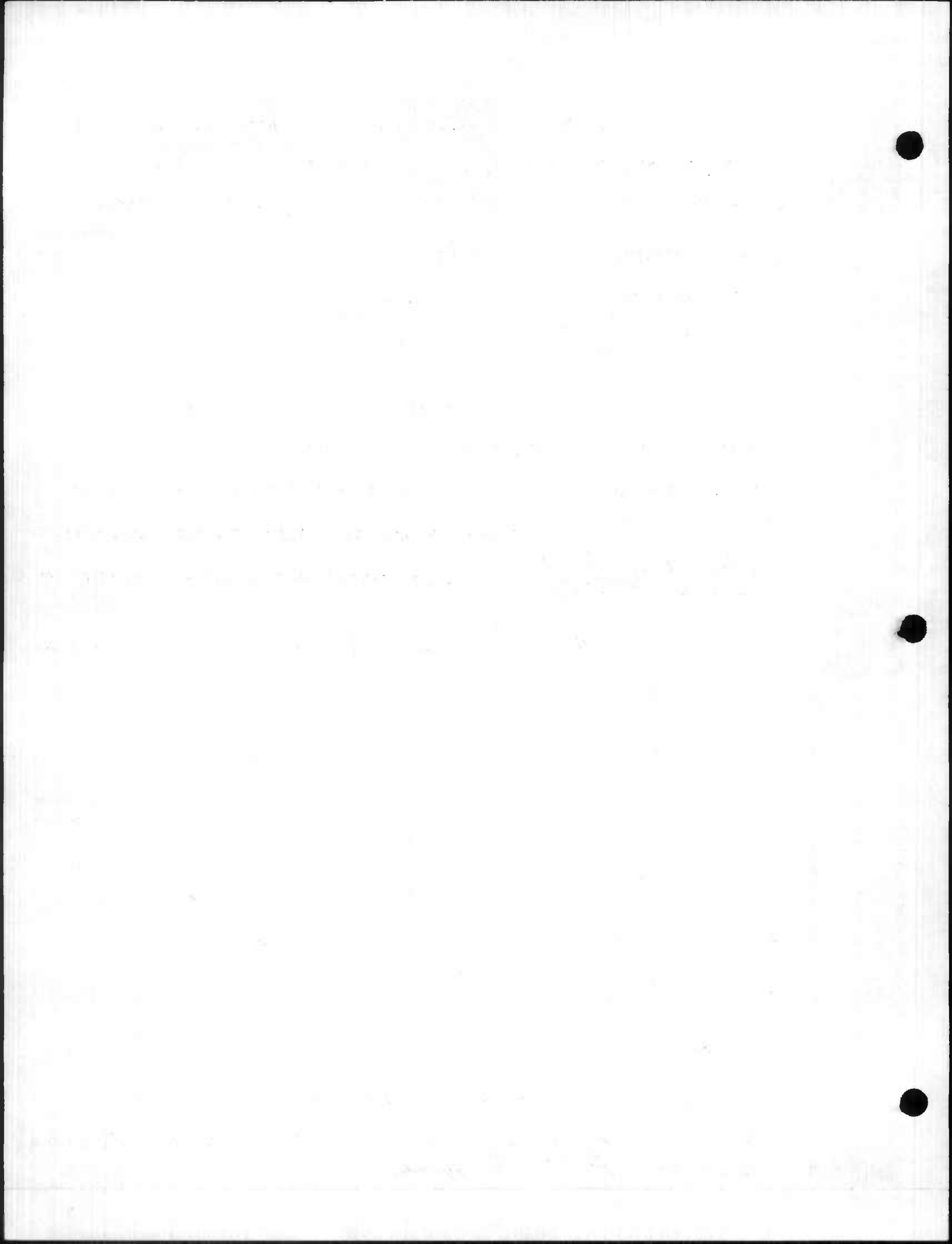
23ai. Were en autopsy performed? 1 Yes 2 No 23aj. Were en autopsy performed? 1 Yes 2 No

23ak. Were en autopsy performed? 1 Yes 2 No 23al. Were en autopsy performed? 1 Yes 2 No

23am. Were en autopsy performed? 1 Yes 2 No 23an. Were en autopsy performed? 1 Yes 2 No

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42796

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WALTER MILLER WHITE				2. Date of Death Month December Day 16 Year 1999		3. Time of Death 1220	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 220-32-0624		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) 3/6/1914	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Somerset		10c. City, Town or Location Princess Anne	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 14015 Cooley Road		10f. Zip Code 21853		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: Navy		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant		16b. Kind of Business/Industry retail tire		17. Father's Name (First, Middle, Last) Southey King White	
	18. Mother's Name (First, Middle, Maiden Surname) Iris Tull		19a. Informant's Name/Relationship (Type, Print) Peggy C. White (wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14015 Cooley Rd., Princess Anne, MD 21853		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery		20c. Date 12/18/99		20d. Location - City or Town, State Salisbury, MD		21. Signature of Funeral Service Licensee MO1051 <i>David H. Thompson</i>	
	22. Name and Address of Facility Holloway Funeral Home, P.A. 501 Snow Hill Rd., Salisbury, MD 21804		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 19 years		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier James F. Cliffe MD		29c. License number A0001969		29d. Date signed (Month, Day, Year) 12-16-99		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES H. CLIFFORD M.D. 106 PINE BLUFF RD Suite 12 SALISBURY, MD 21804	
State Registrar	31. Date filed (Month, Day, Year) DEC 20 1999		32. Registrar's Signature B. Sparks		33. Date of Death (Month, Day, Year) 12-16-99		34. Time of Death (Month, Day, Year) 1220	

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42797

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES

EDWARD

WHITE

2. Date of Death

Month

Day

Year

December 15 1999

3. Time of Death

0633

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

213-22-7536

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

SEPT. 9, 1927

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

WILLARDS

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7290 RICHARDSON STREET

10f. Zip Code

21874

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: WHITE

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

FARMER

16b. Kind of Business/Industry

AGRICULTURE

17. Father's Name (First, Middle, Last)

HOMER

L.

WHITE

18. Mother's Name (First, Middle, Maiden Surname)

M.

FLORENCE

SHOCKLEY

19a. Informant's Name/Relationship (Type, Print)

BETTY JEAN WHITE/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7290 RICHARDSON ST., WILLARDS, MARYLAND 21874

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

LEWIS CEMETERY

Date

12/18/99

20c. Location - City or Town, State

WILLARDS, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. prostate carcinoma
Due to (or as a consequence of):Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rodney A. Wernich, M.D.

29c. License number

D15384

29d. Date signed (Month, Day, Year)

12/15/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RODNEY A. WERNICH

100 POWER ST.

SALISBURY

MD. 21804

31. Date filed (Month, Day, Year)

DEC 20 1999

32. Registrar's Signature

B. Sparks

State
Registrar

ORIGINAL

213-22-7536
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

7+1VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Robert Willing

Certificate of Death

Reg. No.

99 42798

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert S. Willing				2. Date of Death Month Day Year December 13, 1999				3. Time of Death 9:11A.M.		
	4a. Facility Name (If not institution, give street and number) 9043 Bistate Blvd.				4b. City, Town, or Location of Death Delmar				4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 221-12-7620		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) May 18, 1922		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Delmar				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 9043 Bi-State Blvd.				10f. Zip Code 21875				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner & Operator				16b. Kind of Business/Industry Fuel Oil Co.			
17. Father's Name (First, Middle, Last) Arthur Gorman Willing				18. Mother's Name (First, Middle, Maiden Surname) Emily Bradley							
19a. Informant's Name/Relationship (Type, Print) Roberta W. Plant/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5033 Charlemagne Way, Lilburn, GA 30047							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Cambridge Crematory 12-16			20c. Location - City or Town, State Cambridge, MD					
21. Signature of Funeral Service Licensee <i>William M. Short</i>				22. Name and Address of Facility Short Funeral Home 13 E. Grove St., Delmar, DE 19940							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive atherosclerotic cardiovascular disease Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? Limited 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Stephen S. Radentz, MD</i>				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) December , 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201											
State Registrar		31. Date filed (Month, Day, Year) DEC 17 1999		32. Registrar's Signature <i>Bernice B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42799

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Henry Marion Yates

2. Date of Death

December 20, 1999

3. Time of Death

0755

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

214-30-8539

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Dec. 30, 1930

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Delmar

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

204 E. Elizabeth Street

10f. Zip Code

21875

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1949-50

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Railroad Engineer

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

William C. Yates

18. Mother's Name (First, Middle, Maiden Surname)

Ora I. Burchett Yates

19a. Informant's Name/Relationship (Type, Print)

Shirley Yates/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

204 E. Elizabeth Street Delmar, MD 21875

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Bowen Cemetery

Date

12-23-99

20c. Location - City or Town, State

Newark, Maryland

21. Signature of Funeral Service Licensee

William M. Short

22. Name and Address of Facility

Short Funeral Home

13 E. Grove St. Delmar, DE 19940

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DM, type II

Due to (or as a consequence of):

c. Ischemic Heart Disease

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alon Davis MD

29c. License number

DS0054127

29d. Date signed (Month, Day, Year)

12/20/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alon Davis 3 Bistade Blvd Delmar MD 21875

State
Registrar

31. Date filed (Month, Day, Year)

DEC 23 1999

32. Registrar's Signature

B. Sparks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42800

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MAGUY Therese ABU-TAHA

2. Date of Death

NOVEMBER 21, 1999

3. Time of Death

10:50 AM

4a. Facility Name (If not institution, give street and number)

100 Harrison Ct.

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral
Director

5. Social Security Number

578-54-9685

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 16, 1938

9. Birthplace (State or Foreign Country)

France

Usual Residence of Decedent

10a. State

Md.

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

100 Harrison Ct.

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Hair Dresser

16b. Kind of Business/Industry

Beauty Salon

17. Father's Name (First, Middle, Last)

Amor Jean Mehiz

18. Mother's Name (First, Middle, Maiden Surname)

Francoise Eugenie Bourgne

19a. Informant's Name/Relationship (Type, Print)

Patrick Y. Coajou (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

100 Harrison Ct. Frederick, Md. 21702

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

Nov.

20c. Location - City or Town, State

Smithsburg, Md.

21. Signature of Funeral Service Licensee

Pennis L. Davis

22. Name and Address of Facility

12525 Bradbury Ave.
Davis Funeral Home Smithsburg, Md. 21783

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Squamous ADENO-CARCINOMA of the BREAST*
Due to (or as a consequence of): *Metastases*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic pulmonary emphysema

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George I. Smith, M.D. VPM

29c. License number

D 10587

29d. Date signed (Month, Day, Year)

12/7/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*George I. Smith, M.D. Vice Pres Med Affairs**FREDERICK MEHOLAN 115P**FREDERICK, MARYLAND 21701*

31. Date filed (Month, Day, Year)

JAN 27 2000

32. Registrar's Signature

*Bernice G. Sparks*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42801

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) THOMAS Edward Berry				2. Date of Death Month December Day 25 Year 1999		3. Time of Death 16:53PM	
4a. Facility Name (If not institution, give street and number) John Hopkins Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death	
5. Social Security Number 348-32-8319		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		8. Date of Birth (Month, Day, Year) Feb 22 1940	
9. Birthplace (State or Foreign Country) Conn		10a. State MD		10b. County		10c. City, Town or Location Ocean City	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 14101 Dukes Lane		10f. Zip Code 21842		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: 1956-60		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Statistician		16b. Kind of Business/Industry US Gov't		17. Father's Name (First, Middle, Last) Thomas Wayne Berry	
18. Mother's Name (First, Middle, Maiden Surname) Madeline Syrett		19a. Informant's Name/Relationship (Type, Print) Thomas Wayne Berry/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9296 Green Meadows Rd. Warrenton, VA 20187		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) Everly CREMATORY		Date 12/28/99		20c. Location - City or Town, State Alexandria, VA		21. Signature of Funeral Service Licensee [Signature]	
22. Name and Address of Facility Everly-Wheatley Funeral Home 1500 W Braddock Rd. Alex. VA 22302		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) VIRAL INFECTION Due to (or as a consequence of): STATUS POST ALLOGENEIC BONE MARROW TRANSPLANT Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last CYTOMEGALOVIRUS INFECTION Due to (or as a consequence of): ACUTE MYELOGENOUS LEUKEMIA		Approximate Interval Between Onset and Death 1 WEEK 3 MONTHS 2 MONTHS 1 YEAR		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) 12/28/99		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier Rahul Garg MD		29c. License number RES-000		29d. Date signed (Month, Day, Year) DECEMBER 25, 1999		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAHUL GARG, MD 600 N. WOLFE STREET, BALTIMORE, MD 21287	
31. Date filed (Month, Day, Year) JAN 21 2000		32. Registrar's Signature [Signature]		33. Registrar's Title [Signature]		34. Registrar's Name [Signature]	

To Be Completed by Funeral Director

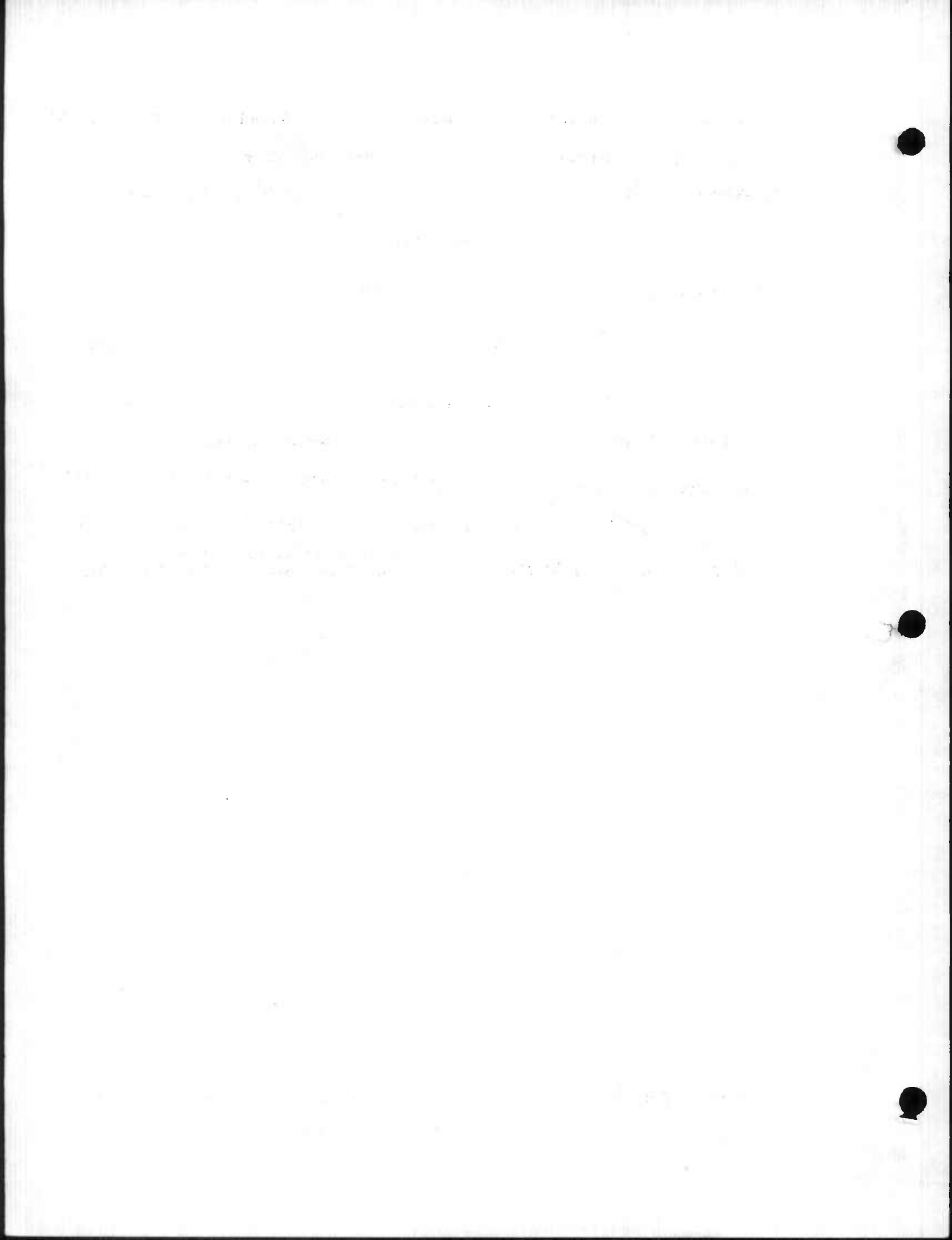
To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42802

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Marie Charles

2. Date of Death

November 3, 1999

3. Time of Death

11:50 AM

4a. Facility Name (If not institution, give street and number)

Prince George Comm. Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince Georges

Funeral
Director

5. Social Security Number

262-56-2243

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 13 1910

9. Birthplace (State or Foreign Country)

Cairo, Ga.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

11307 Lake Front Ct.

10f. Zip Code

20721

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Matthew Hines

18. Mother's Name (First, Middle, Maiden Summa)

Jenie Hadley Hines

19a. Informant's Name/Relationship (Type, Print)

Dr. Velma Charles Shannon Daughter 1137 Lake Front Ct. Mitchellville MD 20721

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Rest Haven Cemetery

Data

Nov 13
1999

20c. Location - City or Town, State

Tampa, Florida

21. Signature of Funeral Service Licensee

cco348

22. Name and Address of Facility

Latney's Funeral Home

3831 Georgia Ave. NW Washington DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Cardiac Arrest

a. Due to (or as a consequence of):

Ascad

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)29b. Signature and title of certifier
29c. License number
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Dr. Joseph Braun PG Hospital 3001 Hospital Dr. Cheverly, MD.

31. Date filed (Month, Day, Year)

JAN 27 2000

32. Registrar's Signature

State
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42803

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

LINDA MARIE HARRISON

2. Date of Death

December 13 1999

Day Year

3. Time of Death

1217

4a. Facility Name (If not institution, give street and number)

SHROY GLOBE ACCOUNTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral
Director

5. Social Security Number

191-38-5679

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 14, 1948

9. Birthplace (State or Foreign Country)

Reading, Pa.

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

GERMANTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12606 GREY EAGLE CT. #34

10f. Zip Code

20874

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
unknown

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nursing assistant

16b. Kind of Business/Industry

Health care

17. Father's Name (First, Middle, Last)

Ralph Liggs

18. Mother's Name (First, Middle, Maiden Surname)

Eloise Lusane

19a. Informant's Name/Relationship (Type, Print)

Tanya Simmons - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

732 Weiser Street, Reading, Pa. 19601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Birdsolo/ St. Michaels

Date

12/20/99 Reading, Pa.

21. Signature of Funeral Service Licensee

Thomas E. Hombaker

22. Name and Address of Facility

Theo. Auman, Inc.

247 Penn Street, Reading, Pa. 19601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ANTERIOCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

015236

29d. Date signed (Month, Day, Year)

December 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARE MARQUIS, MD - 1125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

31. Date filed (Month, Day, Year)

JAN 20 2000

32. Registrar's Signature

Denise B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

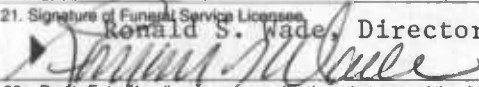

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: 19A-B PER ANATOMY BOARD 6779-1-21-2000 WR.

Reg. No.

99 42804

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HARRIS BABY A (un named)					2. Date of Death Month Day Year Dec. 27 1999		3. Time of Death 04:40			
	4a. Facility Name (If not Institution, give street and number) University of Maryland Medical System				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A				
Funeral Director	5. Social Security Number NONE		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 2 Months 24 Days 24		8. Date of Birth (Month, Day, Year) Dec 27, 1999		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent										
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 2502 Druid Hill Ave					10f. Zip Code 21217			10g. Citizen of What Country? USA			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) none College (1-4 or 5+) none					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none			16b. Kind of Business/Industry none			
17. Father's Name (First, Middle, Last) unknown					18. Mother's Name (First, Middle, Maiden Surname) Teneara Harris						
19a. Informant's Name/Relationship (Type, Print) TENEARA HARRIS/MOTHER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2502 DRUID HILL AVE. BALTO, MD 21217						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state					20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee  Ronald S. Wade, Director					22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <div style="text-align: center;">Prematurity</div> Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <div style="text-align: center;">b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.</div>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  Benita B. Sparks MD					29c. License number P13879			29d. Date signed (Month, Day, Year) JANUARY 7, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St., Baltimore, Md 21201											
State Registrar		31. Date filed (Month, Day, Year) JAN 21 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42805

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ethel M. James						2. Date of Death Month Day Year DECEMBER 10, 1999		3. Time of Death 10:22 AM	
	4a. Facility Name (If not institution, give street and number) 20 Shady Ridge Court						4b. City, Town, or Location of Death Parkton		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-01-8358		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 16, 1921		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Parkton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 20 Shady Ridge Court				10f. Zip Code 21120		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife			16b. Kind of Business/Industry own home			
	17. Father's Name (First, Middle, Last) Robert Ooyle					18. Mother's Name (First, Middle, Maiden Surname) Marie Steele				
	19a. Informant's Name/Relationship (Type, Print) Charles James / son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Shady Ridge Court Parkton, MD 21120				
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director PER OVR					22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. SUDDEN DEATH Due to (or as a consequence of): b. PROBABLE ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIDDM, colon cancer, breast cancer Peptic ulcer disease, previous CVA										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier George N. Karikar MD					29c. License number D16189		29d. Date signed (Month, Day, Year) 1-15-2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE N. KARIKAR MD, 6565 N. CHARLES ST. SUITE 615 TOWSON MD 21204										
State Registrar	31. Date filed (Month, Day, Year) JAN 24 2000		32. Registrar's Signature Benjamin B. Sparks							

1/21/00 G.Sparks okayed acceptance of Item 1/dhb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42806

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wilhelm Jorgensen				2. Date of Death Month Day Year DECEMBER 26, 1999		3. Time of Death 0706 AM		
	4a. Facility Name (If not institution, give street and number) BAYVIEW MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death		
Funeral Director	5. Social Security Number unknown		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		6. Under 1 Year Months Days		
	6. Under 24 Hrs. Hours Min.		8. Date of Birth Month Day Year DEC 1, 1938		9. Birthplace (State or Foreign Country) unknown				
Usual Residence of Decedent									
10a. State unknown		10b. County unknown		10c. City, Town or Location unknown			10d. Inside City Limits unknown <input type="checkbox"/> <input type="checkbox"/> No		
10e. Street and Number unknown				10f. Zip Code unknown		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unknown unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown		16b. Kind of Business/Industry unknown			
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown					
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) in state		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201					
23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Hypothermia in association with Chronic Alcoholism b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DQA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 12/26/99		28b. Time of Injury (Hour, Min) 0600 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject exposed to cold environment.	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Bus Stop/Street; Fayette St. and Highland St.; Baltimore, Md.				28f. Location (Street and Number or Rural Route Number, City, or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Joseph Pestaner, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) DECEMBER 27, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) JAN 24 2000				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 27 per DR,G7802/16/00dhh

State of Maryland / Department of Health and Mental Hygiene

Amended Item#23aptII perPhyG779 1/21/2000 EW

Certificate of Death

Reg. No.

99 42807

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenneth J. Kyle				2. Date of Death Month December Day 23 , Year 1999		3. Time of Death 2:30 PM	
	4a. Facility Name (If not institution, give street and number) 413 Arcadia Drive				4b. City, Town, or Location of Death Joppa		4c. County of Death Harford	
Funeral Director	5. Social Security Number 482-46-7775	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 30, 1939		9. Birthplace (State or Foreign Country) Iowa
	Usual Residence of Decedent							
10a. State MD		10b. County Harford		10c. City, Town or Location Joppa			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 413 Arcadia Drive				10f. Zip Code 21085		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto instructor			16b. Kind of Business/Industry education	
17. Father's Name (First, Middle, Last) Lyle J. Kyle				18. Mother's Name (First, Middle, Maiden Surname) Dorothy Fehr				
19a. Informant's Name/Relationship (Type, Print) Delores Kyle/spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Arcadia Drive Joppa Md. 21085				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. NON SMALL CELL LUNG CANCER Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 6 MONTHS
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STROKES MULTIPLE CEREBROVASCULAR ACCIDENTS								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred	
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D 31775		29d. Date signed (Month, Day, Year) DECEMBER 29, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOAN P. EDWARDS, M.D. 7112 BELAIR ROAD FAUSTON, MARYLAND 21047								
31. Date filed (Month, Day, Year) JAN 21 2000				32. Registrar's Signature [Signature]				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42808

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Beulah Mae Lawrence

2. Date of Death

12 30 99

3. Time of Death

6:30 P

Funeral
Director

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

5. Social Security Number

232-32-7111

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12-5-28

9. Birthplace (State or Foreign Country)

Maysville, WV

Usual Residence of Decedent

10a. State

WV

10b. County

Tucker

10c. City, Town or Location

Davis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

PO Box 691

10f. Zip Code

26260

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Quality inspector

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Andrew Christian Rohrbaugh

18. Mother's Name (First, Middle, Maiden Surname)

Nora Mae Goldizen

19a. Informant's Name/Relationship (Type, Print)

Betty Sponaule

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 145 Davis WV 26260

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Rohrbaugh Cemetery

Date

1-2-00

20c. Location - City or Town, State

Dry Fork, WV

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hinkle Funeral Home, Inc.

PO Box 186, Davis WV 26260

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia

Approximate Interval Between Onset and Death

1 week

Due to (or as a consequence of):

b. chronic obstructive pulmonary disease/respiratory

years

Due to (or as a consequence of):

failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

atherosclerotic heart disease/sp myocardial infarction

high blood pressure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15333

29d. Date signed (Month, Day, Year)

11/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas G. Johnson, M.D. 311 N. Fourth Street Oakland, MD 21550

31. Date filed (Month, Day, Year)

JAN 19 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Thomas Anthony McKnight

Certificate of Death

Reg. No. 99-42809

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas Anthony McKnight, Sr.				2. Date of Death Month Day Year December 24 1999		3. Time of Death 02:15 AM.				
	4a. Facility Name (If not institution, give street and number) Martin Luther King Blvd. & Flaggstaff Rd.				4b. City, Town, or Location of Death Landover		4c. County of Death Prince George's				
Funeral Director	5. Social Security Number 577-74-5232		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 43 Yrs.		6. Date of Birth (Month, Day, Year) Jun. 25, 1956		9. Birthplace (State or Foreign Country) Wash., D.C.		
	Usual Residence of Decedent										
10a. State Md.		10b. County Prince Georges		10c. City, Town or Location Lanham				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 9113 Fowler Lane				10f. Zip Code 20706		10g. Citizen of What Country? U.S.A.					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer			16b. Kind of Business/Industry Construction				
17. Father's Name (First, Middle, Last) Lawrence Hill				18. Mother's Name (First, Middle, Maiden Surname) Barbara Hamilton							
19a. Informant's Name/Relationship (Type, Print) Catherine McKnight (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9113 Fowler Ln., Lanham, Md. 20706							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Hill Cemetery			Date 1-17		20c. Location - City or Town, State Clinton, Md.			
21. Signature of Funeral Service Licensee Phillip Bell				22. Name and Address of Facility Phillip Bell Funeral Service 4902 Stan Haven Rd., Temple Hills, Md. 20748							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of):								Approximate Interval Between Onset and Death		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 12/24/99		28b. Time of Injury 0210 HR		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject high, hit by vehicle			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway								28f. Location (Street and Number or Rural Route Number, City or Town, State) Martin Luther King Blvd. & Flaggstaff Road, Landover, Md.	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Theodore M. King M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) December 25, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JAN 27 2000		32. Registrar's Signature Benjamin B. Sparks									

99-7859-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

NATHANIEL

State of Maryland / Department of Health and Mental Hygiene

NOBLE AMEND ITEMS: #23 PART I, 27 PER MEO

Certificate of Death

Reg. No.

99 42810

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NATHANIEL NOBLE				2. Date of Death Month Day Year DECEMBER 29, 1999				3. Time of Death 3:15 P.M.			
	4a. Facility Name (If not institution, give street and number) UNION MEMORIAL HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death			
Funeral Director	5. Social Security Number UNKNOWN		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) March 22, 1951		9. Birthplace (State or Foreign Country) unknown	
	Usual Residence of Decedent											
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number 2524 N. Charles Street				10f. Zip Code 21218				10g. Citizen of What Country? USA				
11. Marital Status unknown 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown				16b. Kind of Business/Industry unknown				
17. Father's Name (First, Middle, Last) unknown						18. Mother's Name (First, Middle, Maiden Surname) unknown						
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street, Baltimore, MD 21201						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) Date		20c. Location - City or Town, State						
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death		
a. PONTINE HEMORRHAGE Due to (or as a consequence of): b. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier J. M. T. M.D.						29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) DECEMBER 31, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TINS M.D. 111 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) JAN 24 2000				32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42811

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Martha Peirson				2. Date of Death Month Day Year Dec. 26 1999		3. Time of Death 12:35PM	
	4a. Facility Name (If not institution, give street and number) Sunbridge Care and Rehab				4b. City, Town, or Location of Death Elkton, Maryland		4c. County of Death Cecil	
Funeral Director	5. Social Security Number 221-07-3822		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 100 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 03 1899	
	9. Birthplace (State or Foreign Country) Pennsylvania		10. Usual Residence of Decedent 10a. State Delaware		10b. County New Castle		10c. City, Town or Location Yorklyn	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number P. O. Box #87		10f. Zip Code 19709		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Household			
	17. Father's Name (First, Middle, Last) Charles Peirson				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth O. Ryan			
	19a. Informant's Name/Relationship (Type, Print) Howard A. Magargal (grandson)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 New Road, Lewes, Delaware 19958			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Silverbrook Crematory		20c. Location - City or Town, State Wilmington, Delaware		20d. Date Jan 2000	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiopulmonary Failure</u> Due to (or as a consequence of): b. <u>ASVS</u> Due to (or as a consequence of): c. <u>HTN</u> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and Title of Certifier 				29c. License number H0055026		29d. Date signed (Month, Day, Year) December 27, 1999	
State Registrar	30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Dr. Stephen Naylor, MD. 20 Craigtown Road, Port Deposit, Maryland 21904							
	31. Date filed (Month, Day, Year) JAN 20 2000				32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42812

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HAZEL RUDOLPH						2. Date of Death Month Day Year DECEMBER 30, 1999		3. Time of Death 1:15 PM	
	4a. Facility Name (If not institution, give street and number) 514 Patterson Avenue						4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegheny	
Funeral Director	5. Social Security Number 212-38-6268		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) Dec 12, 1912		9. Birthplace (State or Foreign Country) WV	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Allegheny		10c. City, Town or Location Cumberland				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 514 Patterson Avenue				10f. Zip Code 21502		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collage (1-4or 5+) unknown		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) beautician			16b. Kind of Business/Industry cosmotology				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Bud Enow Carr						18. Mother's Name (First, Middle, Maiden Surname) Martha L. Mick			
	19a. Informant's Name/Relationship (Type, Print) Richard Rudolph/son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10300 Columbus Ave NE Cumberland, MD 21502			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)		Data		20c. Location - City or Town, State		
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death greater than five years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Terry F. Williams		29c. License number D16041		29d. Date signed (Month, Day, Year) 01-18-00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terry F. Williams, M.D. 500 Memorial Avenue Cumberland, MD 21502									
State Registrar	31. Date filed (Month, Day, Year) JAN 24 2000									
32. Registrar's Signature Beverly S. Sparks										

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42813

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rose Y. Strausser				2. Date of Death Month Day Year Dec. 30 1999		3. Time of Death 8:45 PM															
	4a. Facility Name (If not institution, give street and number) Mariner Health Care				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore															
Funeral Director	5. Social Security Number 215-07-5764		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) 01-01-1907															
	Usual Residence of Decedent		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Catonsville															
To Be Completed by Funeral Director	10e. Street and Number 98 Smithwood Avenue		10f. Zip Code 21228		10g. Citizen of What Country? U.S.A.		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No															
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White															
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry																	
	17. Father's Name (First, Middle, Last) Donato Macciola				18. Mother's Name (First, Middle, Maiden Surname) Leondina																	
	19a. Informant's Name/Relationship (Type, Print) Michael King/ Grandson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2102 Moonlight Drive, Hampstead, Maryland 21074																	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 1-3-2000															
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Ave., Baltimore, Maryland 21229																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Dehydration</i></td> <td>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death <i>7d</i></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <i>end stage Alzheimer's disease</i></td> <td>Due to (or as a consequence of):</td> <td><i>5 yrs</i></td> </tr> <tr> <td>c. <i>a few scientific disease</i></td> <td>Due to (or as a consequence of):</td> <td><i>20 yrs</i></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Dehydration</i>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>7d</i>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>end stage Alzheimer's disease</i>	Due to (or as a consequence of):	<i>5 yrs</i>	c. <i>a few scientific disease</i>	Due to (or as a consequence of):	<i>20 yrs</i>	d.		
	Immediate Cause (Final disease or condition resulting in death)	a. <i>Dehydration</i>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death <i>7d</i>																		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. <i>end stage Alzheimer's disease</i>	Due to (or as a consequence of):	<i>5 yrs</i>																			
	c. <i>a few scientific disease</i>	Due to (or as a consequence of):	<i>20 yrs</i>																			
	d.																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																						
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																						
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier <i>[Signature]</i> physician		29c. License number D 29769		29d. Date signed (Month, Day, Year) 01/03/00																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Marcelino D. Albuquerque</i> 1120 W. Rolling Rd. Balt. Md.																						
31. Date filed (Month, Day, Year) JAN 24 2000		32. Registrar's Signature <i>[Signature]</i>																				

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 26 per M.D G-779 1/27/2000 reb

Certificate of Death

Reg. No. 99 42814

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred E. Williams

2. Date of Death

Month Day Year
Sept. 21 1999

3. Time of Death

11:10 AM

4a. Facility Name (If not institution, give street and number)

1417 Shady Glen Drive

4b. City, Town, or Location of Death

Forestville

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

227-20-0790

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug 11 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

VA

10b. County

James City

10c. City, Town or Location

Williamsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

6243 Mooretown Road

10f. Zip Code

23188

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Wmsburg-James City Co School Board

17. Father's Name (First, Middle, Last)

George Christian

18. Mother's Name (First, Middle, Maiden Surname)

Mariah Knight

19a. Informant's Name/Relationship (Type, Print)

Shirley Montague/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1417 Shady Glen Dr., Forestville, MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Williamsburg Mem. Park

Date

9-28-99

20c. Location - City or Town, State

Williamsburg, VA

21. Signature of Funeral Service Licensee

CO0348

22. Name and Address of Facility

Latney, s Funeral Home, Inc.
3831 Georgia Ave., NW, Wash., DC 20011

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the causa of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☒ Other (Specify)

Daughter's Home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 8 ☐ Could not be determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES 0001

29d. Date signed (Month, Day, Year)

November 2, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles G. Drake 600 N. Walh St., Baltimore MD 21287 (John Hopkins Hospital)

31. Date filed (Month, Day, Year)

JAN 27 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Charles & Charles 185001 1899

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42815

AMEND ITEMS: #20B-C PER F.H. G7780 2-19-2000

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Raymond G. Alban</i>						2. Date of Death Month <i>Dec</i> 31, Day 1999 Year		3. Time of Death 1:00 pm	
	4a. Facility Name (If not institution, give street and number) <i>Genesis Eldercare</i>						4b. City, Town, or Location of Death <i>Randallstown</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>199-03-0467</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>80</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Mar 17, 1919</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <i>Maryland</i>		10b. County <i>Carroll</i>		10c. City, Town or Location <i>Manchester</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <i>3080 Main Street</i>				10f. Zip Code <i>21102</i>		10g. Citizen of What Country? <i>USA</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>5</i> <i>College (1-4or 5+)</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Tree Trimmer</i>			16b. Kind of Business/Industry <i>Asplunh Tree Co</i>		
	17. Father's Name (First, Middle, Last) <i>William Simon Alban</i>						18. Mother's Name (First, Middle, Maiden Surname) <i>Ida Cora Alban</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Donald Alban, son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>14224 Old Hanover Rd, Reisterstown, MD 21136</i>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Black Rock Cemetery</i>		Date <i>1/3/2000</i>		20c. Location - City or Town, State <i>Hampstead, MD</i>	
	21. Signature of Funeral Service Licensee <i>Heavenly Wines</i> <i>MD0723</i>				22. Name and Address of Facility <i>Eline Funeral Home</i> <i>934 South Main St, Hampstead, MD 21074</i>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Arteriosclerosis</i> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Chronic organic brain syndrome</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier <i>Jerome H. Ginsberg</i>				29c. License number <i>D0020964</i>		29d. Date signed (Month, Day, Year) <i>January 3, 2000</i>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133</i>									
31. Date filed (Month, Day, Year) <i>JAN 07 2000</i>		32. Registrar's Signature <i>Gene P. Sparks</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

MATILDA
BEATTY

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42816

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Matilda R. Beatty				2. Date of Death Month Day Year DECEMBER 31, 1999				3. Time of Death 10:49A.M.	
	4a. Facility Name (If not institution, give street and number) 16010 EXCALUBER ROAD				4b. City, Town, or Location of Death BOWIE				4c. County of Death PRINCE GEORGES	
Funeral Director	5. Social Security Number 220 32 6451		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 62 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Nov. 15, 1937		9. Birthplace (State or Foreign Country) unk.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie	
Usual Residence of Decedent										
10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 16010 Excalibur Road		10f. Zip Code 20716		10g. Citizen of What Country? United States				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper				16b. Kind of Business/Industry Private Industry		
17. Father's Name (First, Middle, Last) Dwight S. Thomas					18. Mother's Name (First, Middle, Maiden Surname) Lillian O. Mathis					
19a. Informant's Name/Relationship (Type, Print) Tom James Nephew					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15504 Norge Court Bowie Maryland 20716					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery			20c. Location - City or Town, State Brentwood Maryland				
21. Signature of Funeral Service Licensee Todd Liller					22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pyelonephritis</u> Due to (or as a consequence of): b. <u>Renal Stones</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atherosclerotic Cardiovascular disease</u>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier O.C.M.E.					29c. License number			29d. Date signed (Month, Day, Year) JANUARY 1, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Poul 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JAN 10 2000										
32. Registrar's Signature B. Sparks										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6111

ARTHUR
BROWN JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42817

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Arthur L. Brown Jr

2. Date of Death

Month Day Year
DECEMBER 30, 1999

3. Time of Death

5:53P.M.

4a. Facility Name (If not institution, give street and number)

62 nd AVE & TRENT STREET

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

228 159002

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

22

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month/Day/Year
4/13/77

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

VA

10b. County

Fairfax

10c. City, Town or Location

Alexandria

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3033 Fordson Court

10f. Zip Code

22306

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Arthur L. Brown

18. Mother's Name (First, Middle, Maiden Surname)

Aleta Parker

19a. Informant's Name/Relationship (Type, Print)

Aleta Parker mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3033 Fordson Ct Alexandria, VA 22306

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairfax Memorial

Date

8 JAN 2000

20c. Location - City or Town, State

Fairfax, VA

21. Signature of Funeral Service Licensee

Nelson C Green

22. Name and Address of Facility

Greene Funeral Home
814 Franklin St, Alexandria VA 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Gunshot Wounds (2) of HEAD

Approximate Interval Between Onset and Death

Brief

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) SCENE

27. Manner of Death

☐ Natural ☐ Pending Investigation
☐ Accident ☐ Could not be determined
☒ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

12/30/99

28b. Time of Injury

5:53 P M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Victim SHOT

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State)

62nd AVE + TRENT STREET

CHEVERLY, MD

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

J. M. Tims, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 31, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. TIMS, M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

JAN 10 2000

32. Registrar's Signature

B. B. B. B.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene 99 42818

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Barnes Brashears

2. Date of Death

Month Day Year
December 31, 1999

3. Time of Death

4:00 a.m.

4a. Facility Name (If not institution, give street and number)

Crescent Cities Center

4b. City, Town, or Location of Death

Riverdale

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

577-01-2680

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Aug. 7, 1905

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4409 East West Highway

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

White House

U.S. Government

17. Father's Name (First, Middle, Last)

Joseph Brashears

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Yenney

19a. Informant's Name/Relationship (Type, Print)

Olivia B. Suit - Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

311 North Glen Avenue, Annapolis, Maryland 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery


Date

01/05/00

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA COMPLICATING FRACTURES OF

Due to (or as a consequence of)

RIGHT HIP & RIGHT ARM

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

11/26/99

28b. Time of Injury

5:30 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT FELL TO THE FLOOR

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

In Hallway

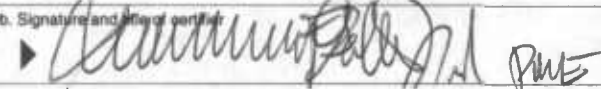
28f. Location (Street and Number or Rural Route Number, City or Town, State)

4409 East-West Highway, Riverdale, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier



29c. License number

D33954

29d. Date signed (Month, Day, Year)

January 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mario F. Golle, Jr., M.D. 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

JAN 14 2000

32. Registrar's Signature

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

0005 1: 1AL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42819

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Matilda Carter

2. Date of Death

December 31, 1999

3. Time of Death

6:15 AM

4a. Facility Name (If not institution, give street and number)

Doctors' Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

422-90-5326

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

37

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 5, 1962

9. Birthplace (State or Foreign Country)

Fairfield, AL

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10723 Kitchner Court

10f. Zip Code

20721

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Robert Carter

18. Mother's Name (First, Middle, Maiden Surname)

Lula Mae Baxer

19a. Informant's Name/Relationship (Type, Print)

Nathaniel Carter - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10723 Kitchner Ct. Mitchellville, MD 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)George Washington
Carver Cemetery

Date

1/7/00

20c. Location - City or Town, State

Birmingham, AL

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Metropolitan Funeral Service, Inc.

5517 Vine Street, Alexandria, VA 22310

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. METASTATIC MALIGNANT

Due to (or as a consequence of):

MESOTHELIOMA

> 2-month

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCITES; stage IV disease;
PARAPLEGIA.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
2 ☐ Accident investigation
3 ☐ Suicide 6 ☐ Could not be
4 ☐ Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-34525

29d. Date signed (Month, Day, Year)

12-31-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.J. Rao, MD; 4000 Mitchellville Road; #220; Bowie-MD 20716.

State
Registrar

31. Date filed (Month, Day, Year)

JAN 10 2000

32. Registrar's Signature

Barbara B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

CARTER, MATILDA
12-31-99 6:15 A.M.
Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42820

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAURA C. DUNCAN						2. Date of Death Month Dec Day 31 Year 1999		3. Time of Death 1340	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Gen. Hospital						4b. City, Town, or Location of Death Annapolis		4c. County of Death AA	
Funeral Director	5. Social Security Number 218-26-7652		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 8, 1930		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 330 Martins Cove Road				10f. Zip Code 21401		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12			College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Bernard Durner						18. Mother's Name (First, Middle, Maiden Surname) Florence Casey				
19a. Informant's Name/Relationship (Type, Print) Patrick Duncan/ Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5314 Glenwood Road. Bethesda, MD. 20814				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cemetery			Date 01-05-00		20c. Location - City or Town, State Arlington, Virginia		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction minutes Due to (or as a consequence of): b. Arteriosclerotic Heart Disease Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										
23b. Part II. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier Deputy William P. Jones			29c. License number D06054		29d. Date signed (Month, Day, Year) 01/01/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William P. Jones, MD 695 America 21035										
31. Date filed (Month, Day, Year) JAN 04 2000			32. Registrar's Signature James B. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

[Faint, illegible handwritten text covering the majority of the page]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42821

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DELLA FRAZIER				2. Date of Death Month Day Year Jan 6 1999		3. Time of Death 8:50 AM	
	4a. Facility Name (If not institution, give street and number) Genesis ElderCare - The Pines				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot	
Funeral Director	5. Social Security Number 218-16-1650		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 1, 1920	
	9. Birthplace (State or Foreign Country) Penna.		10a. State Maryland		10b. County Talbot		10c. City, Town or Location St. Michaels	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 223 Madison Ave.		10f. Zip Code 21663		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner Operator		16b. Kind of Business/Industry Restaurant		17. Father's Name (First, Middle, Last) Harvey Newkirk		
18. Mother's Name (First, Middle, Maiden Surname) Florence Bowman		19a. Informant's Name/Relationship (Type, Print) Florence M. Hood Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 Madison Ave. St. Michaels, Maryland 21663		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Capitol Crematory Jan. 7, 1999		20c. Location - City or Town, State Dover Delaware		21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <i>Hypoxia, acute and chronic</i> Due to (or as a consequence of):		b. <i>Chronic obstructive pulmonary disease</i> Due to (or as a consequence of):		c. Due to (or as a consequence of):		
d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atherosclerosis</i> <i>Coronary artery disease</i> <i>Osteoporosis with vertebral compression fractures</i>		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		
29c. License number 725933		29d. Date signed (Month, Day, Year) 1-7-00		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Michael D. Crowley M.D. 508 Idlewild Ave. Easton, Maryland 21601		31. Date filed (Month, Day, Year) JAN 10 2000		
32. Registrar's Signature <i>[Signature]</i>		33. Registrar's Title B. Sparks		34. State Registrar State Registrar		35. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42822

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>James B. RICHARD</i>		2. Date of Death Month <i>Dec</i> Day <i>30</i> Year <i>1999</i>		3. Time of Death <i>4:10pm</i>
	4a. Facility Name (If not institution, give street and number) <i>Southern Maryland Hospital</i>		4b. City, Town, or Location of Death <i>Clinton</i>		4c. County of Death <i>Prince Georges</i>
Funeral Director	5. Social Security Number <i>215-32-2692</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>65</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>December 19, 1934</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent				
10a. State		10b. County		10c. City, Town or Location <i>Washington, DC</i>	
10e. Street and Number <i>1143 - 44th Place, S.E.</i>		10f. Zip Code <i>20019</i>		10g. Citizen of What Country? <i>U S A</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8th grade</i> College (14 or 5+) <i>College</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Laborer</i>	
16b. Kind of Business/Industry <i>Construction</i>		17. Father's Name (First, Middle, Last) <i>John Forrest Holly, Sr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Pearl Young</i>	
19a. Informant's Name/Relationship (Type, Print) <i>Agnes E. Holly (Spouse)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1143 - 44th Place, S.E., Washington, DC 20019</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Sacred Heart Cemetery</i>		20c. Location - City or Town, State <i>1/7/2000 Bushwood, Maryland</i>	
21. Signature of Funeral Service Licensee <i>Michael K. Gardiner</i>		22. Name and Address of Facility <i>Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <i>a. End stage Prostate Cancer with Metastases to bones</i> Due to (or as a consequence of): <i>b. Pancytopenia</i> Due to (or as a consequence of): <i>c. A. Fibrillation</i> Due to (or as a consequence of): <i>d. Advanced COPD</i>				<i>4 years</i> <i>unknown</i> <i>unknown</i> <i>4 years</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29c. Signature and title of certifier <i>Rouman Farahifar M.D.</i>		29d. License number <i>D43446</i>		29e. Date signed (Month, Day, Year) <i>Dec. 31, 1999</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Suit 3-35</i> <i>ROUMAN FARAHIFAR M.D. 9801 Georgia Ave. Silver Spring MD 20902</i>					
31. Date filed (Month, Day, Year) <i>JAN 04 2000</i>		32. Registrar's Signature <i>Benita B. Sparks</i>			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42823

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Patricia King Hall

2. Date of Death

Month 12 Day 29 Year 99

3. Time of Death

1630

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral
Director

5. Social Security Number

219 01 9240

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
09/12/1921

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crownsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

308 Longpoint Road

10f. Zip Code

21032

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Insurance

Industry

17. Father's Name (First, Middle, Last)

Glen King

18. Mother's Name (First, Middle, Maiden Surname)

Lucia Groeneboom

19a. Informant's Name/Relationship (Type, Print)

Robert H. Bless, Jr. (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

503 Monterey Street, Annapolis MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Metropolitan Crematory

Date

12/31/99

20c. Location - City or Town, State

Alexandria VA

21. Signature of Funeral Service Licensee

Melanie Wilhelm Wagner

22. Name and Address of Facility

Advent Funeral & Cremation Services
Annapolis, Maryland 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Lung Disease

Hypertension

Peripheral Vascular Disease (severe)

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Salvatore S. Lauria, MD

29c. License number

D41034

29d. Date signed (Month, Day, Year)

12/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvatore Lauria, MD 2003 Medical Parkway, Suite 100 Annapolis, MD 21401

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42824**
Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) Katherine Ella Irwin
 2. Date of Death Month Day Year December 31, 1999
 3. Time of Death 2:00 AM

Funeral
Director

4a. Facility Name (If not institution, give street and number) LaPlata Center-Genesis Eldercare
 4b. City, Town, or Location of Death LaPlata
 4c. County of Death Charles
 5. Social Security Number 234-10-8134
 6. Sex 1 ☐ M 2 ☒ F
 7. Age (In yrs. last birthday) 88 Yrs.
 8. Date of Birth (Month, Day, Year) September 26, 1911
 9. Birthplace (State or Foreign Country) West Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent
 10a. State Maryland
 10b. County Charles
 10c. City, Town or Location Waldorf
 10d. Inside City Limits 1 ☐ Yes 2 ☒ No
 10e. Street and Number 2617 Meadowsweet Drive
 10f. Zip Code 20601
 10g. Citizen of What Country? U S A
 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
 14. Race - American Indian, Black, White, etc. Specify: White
 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+)
 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper
 16b. Kind of Business/Industry Retail Sales
 17. Father's Name (First, Middle, Last) Walter P. Kidd
 18. Mother's Name (First, Middle, Maiden Surname) Anne Pitman
 19a. Informant's Name/Relationship (Type, Print) Earl Eldon Irwin (son)
 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3831 Hamilton Street #102, Hyattsville, Maryland 20781
 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
 20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens
 20c. Location - City or Town, State 1/3/2000 Leonardtown, Maryland
 21. Signature of Funeral Service Licenses *Michael L. Gardiner*
 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician
/Medical
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.
 Immediate Cause (Final disease or condition resulting in death) Poor oral intake failure to thrive
 Due to (or as a consequence of):
 e.
 Due to (or as a consequence of):
 b.
 Due to (or as a consequence of):
 c.
 Due to (or as a consequence of):
 d.
 Approximately list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
 27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
 28a. Date of injury (Month, Day, Year)
 28b. Time of injury M
 28c. Injury at Work? 1 ☐ Yes 2 ☐ No
 28d. Describe how injury occurred
 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier *[Signature]* 29c. License number 045737 29d. Date signed (Month, Day, Year) 12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nirmaladevi Gurusamy 6 Post Office Rd Suite 103 Waldorf, MD 20602

31. Date filed (Month, Day, Year) JAN 04 2000 32. Registrar's Signature *[Signature]*

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature and date: 1962 4 10 1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42825

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Katie Elva Johnson

2. Date of Death

Month Day Year
DECEMBER 30, 1999

3. Time of Death

8:00AM

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

578-26-5972

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 24, 1904

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street end Number

45713 Oregon Way

10f. Zip Code

20653

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Charles Briggs Emmons

18. Mother's Name (First, Middle, Maiden Surname)

Katie Cummings

19a. Informant's Name/Relationship (Type, Print)

Laura Ann Redmond / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45713 Oregon Way, Lexington Park, MD 20653

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

All Faith Episcopal

Date

1/4/00

20c. Location - City or Town, State

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

Mary B. Rizzo

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiopulmonary Failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Sepsis

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or Injury
that initiated events
resulting in death) LastApproximate
Interval Between
Onset and Death

hrs

yrs

wks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Leukemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. James P. Jarboe

29c. License number

D 06419

29d. Date signed (Month, Day, Year)

12/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JAMES P. JARBOE

HOLLYWOOD, MD. 20636

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

Benita G. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: KATIE ELVA JOHNSON

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42826

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Bernard Johnson				2. Date of Death Month Day Year December 27, 1999		3. Time of Death 8:46 AM		
	4a. Facility Name (If not institution, give street and number) 20929 Deerwood Park Drive				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 215-46-4132		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) September 3, 1945		
	9. Birthplace (State or Foreign Country) Maryland		10e. State Maryland		10b. County St. Mary's		10c. City, Town or Location Leonardtown		
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number 20929 Deerwood Park Drive				10f. Zip Code 20650		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cable Splicer		16b. Kind of Business/Industry Telephone Company				
	17. Father's Name (First, Middle, Last) John Bernard Johnson				18. Mother's Name (First, Middle, Maiden Surname) Agnes Cecelia Neal				
	19a. Informant's Name/Relationship (Type, Print) Linda Theresa Johnson (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20929 Deerwood Park Drive, Leonardtown, Maryland 20650				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		20c. Location - City or Town, State 12/30/1999 Leonardtown, Maryland				
	21. Signature of Funeral Service Licensee <i>Michael L. Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. <i>Ventricular Fibrillation</i> Due to (or as a consequence of): b. <i>Acute Myocardial Infarction</i> Due to (or as a consequence of): c. <i>Coronary atherosclerosis</i> Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus, type 2</i> <i>Hypertension</i>						23b. Did tobacco use contribute to this cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>John F. Fenwick</i>		29c. License number D013 VO		29d. Date signed (Month, Day, Year) 1.5.2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John F. Fenwick, MD Leonardtown, Maryland 20650									
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature <i>B. Sparks</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

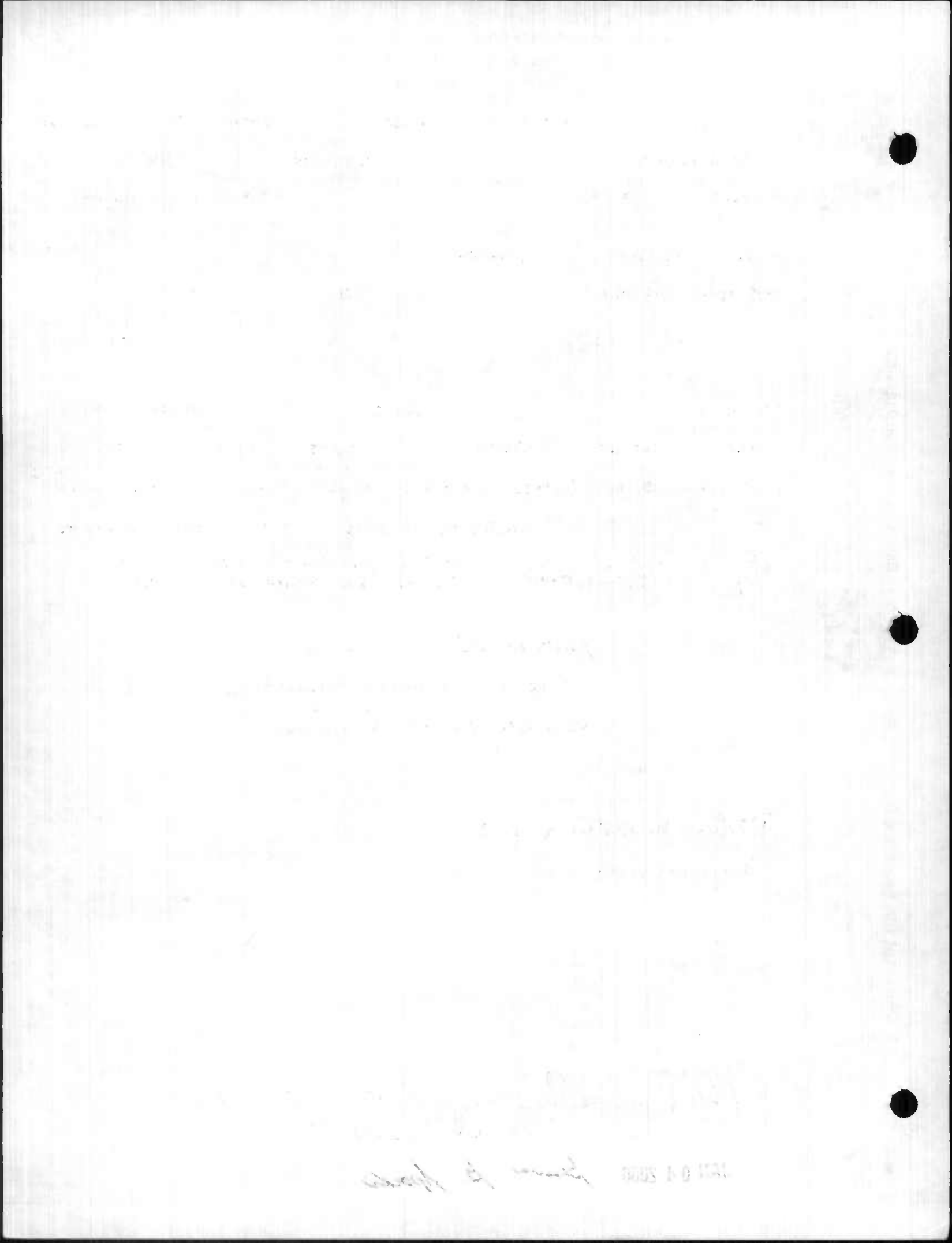
Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar


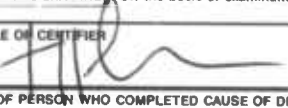
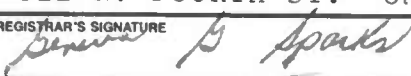


AMEND ITEM: #30 PER V.R. G779 1-28-2000 WR.

99 42827

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

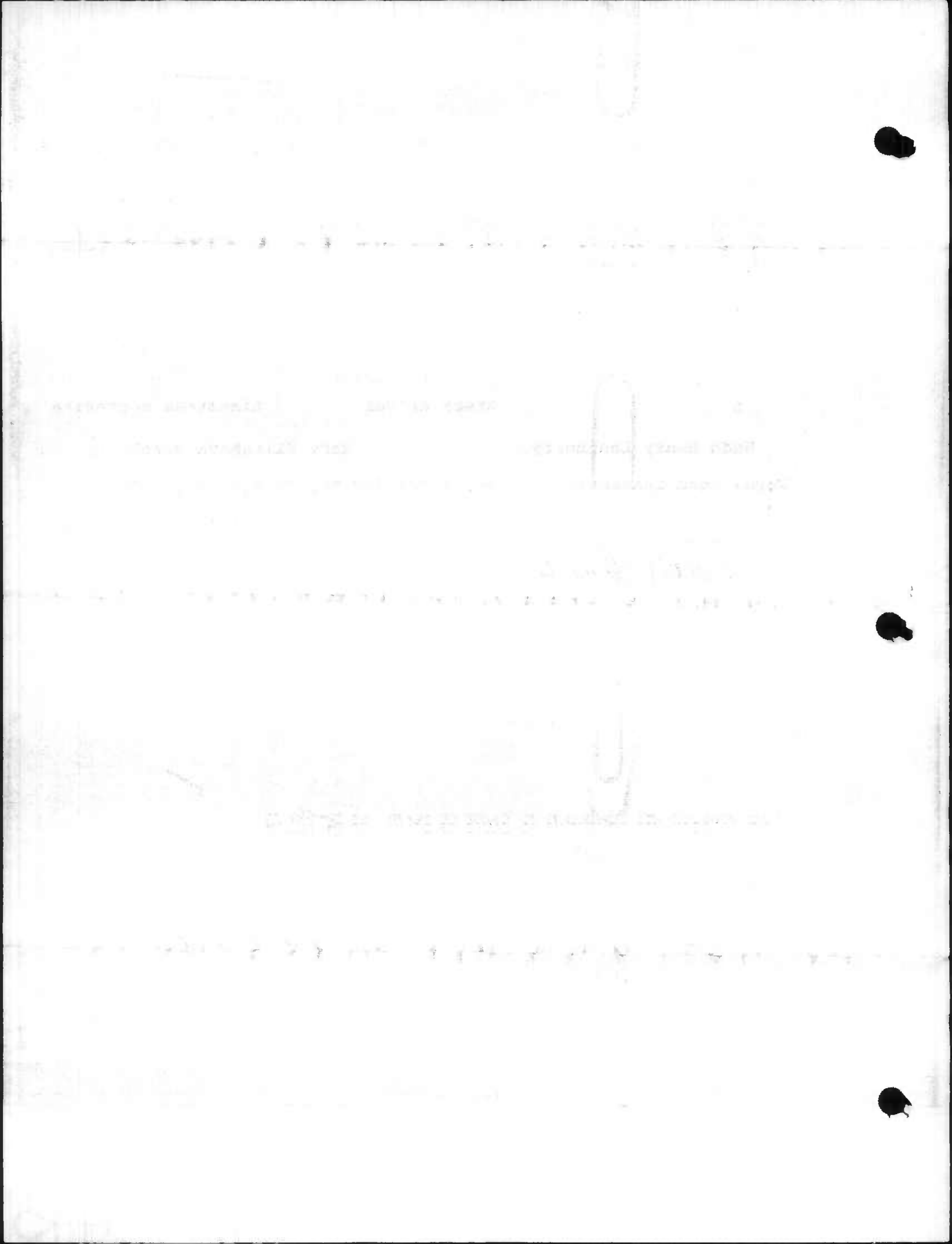
1. DECEDENT'S NAME (First, Middle, Last) John Albert Lansberry				2. DATE OF DEATH MONTH DAY YEAR Dec. 28, 1999		3. TIME OF DEATH 8:40 A.M.	
4. SOCIAL SECURITY NUMBER 379-42-3065		5. SEX XX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 3, 1943	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Oakland	
9c. COUNTY OF DEATH Garrett				10a. STATE WV.		10b. COUNTY Tucker	
10c. CITY, TOWN OR LOCATION Leadmine				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Rt. 2 Box 283	
10f. ZIP CODE 26290				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) truck driver		16b. KIND OF BUSINESS/INDUSTRY Limestone aggregate	
17. FATHER'S NAME (First, Middle, Last) Wade Henry Lansberry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Burch			
19a. INFORMANT'S NAME (Type/Print) Norma Jean Lansberry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 283 St. George, WV. 26290			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery 12/30/1999		20c. LOCATION — City or Town, State Thomas, WV.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hinkle Funeral Home P.O. Box 186 Davis, WV. 26260			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. Cardiogenic Shock DUE TO (OR AS A CONSEQUENCE OF): c. Cerebral Vascular Accident DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D05333		29d. DATE SIGNED (Month, Day, Year) 12/28/99	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS G. JOHNSON 311 N. FOURTH ST. OAKLAND MD 21550							
31. DATE FILED (Month, Day, Year) JAN 28 2000				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #26, per Phy.
1/10/2000, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

99 42828

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Helen G. Logan				2. Date of Death Month Day Year December 27 1999				3. Time of Death 10:40am	
	4a. Facility Name (If not institution, give street and number) 6504 Freedom Avenue				4b. City, Town, or Location of Death Sykesville				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 168 03 7527		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 20, 1919		9. Birthplace (State or Foreign Country) Pa.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 2 Greenwood Rd. P.O.Box 5796				10f. Zip Code 21208		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Domestic	
	17. Father's Name (First, Middle, Last) Harry Brantner				18. Mother's Name (First, Middle, Maiden Surname) Irean Ritchie					
	19a. Informant's Name/Relationship (Type, Print) Gerard Barry Logan (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Greenwood Rd. Baltimore, Md. 21208-5796					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springfield Cemetery		Date 12/31/99		20c. Location - City or Town, State Sykesville, Md.			
	21. Signature of Funeral Service Licensee Harry W. Haight				22. Name and Address of Facility Haight Funeral Home & Chapel P.O.Box 195 Sykesville, Md. 21784					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cardio respiratory arrest Due to (or as a consequence of): b. Brain tumor (glioblastoma multiforme) Due to (or as a consequence of): c. Due to (or as a consequence of): d. {									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> Home Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) N/A		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier Pradip B. Amin MD								
29c. License number D22250		29d. Date signed (Month, Day, Year) Dec 27, 1999								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRADIP B. AMIN MD Dept of Rad. Onc, Univ of Md Hosp, 225 Greene St, Balt 21201										
31. Date filed (Month, Day, Year) JAN 10 2000		32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

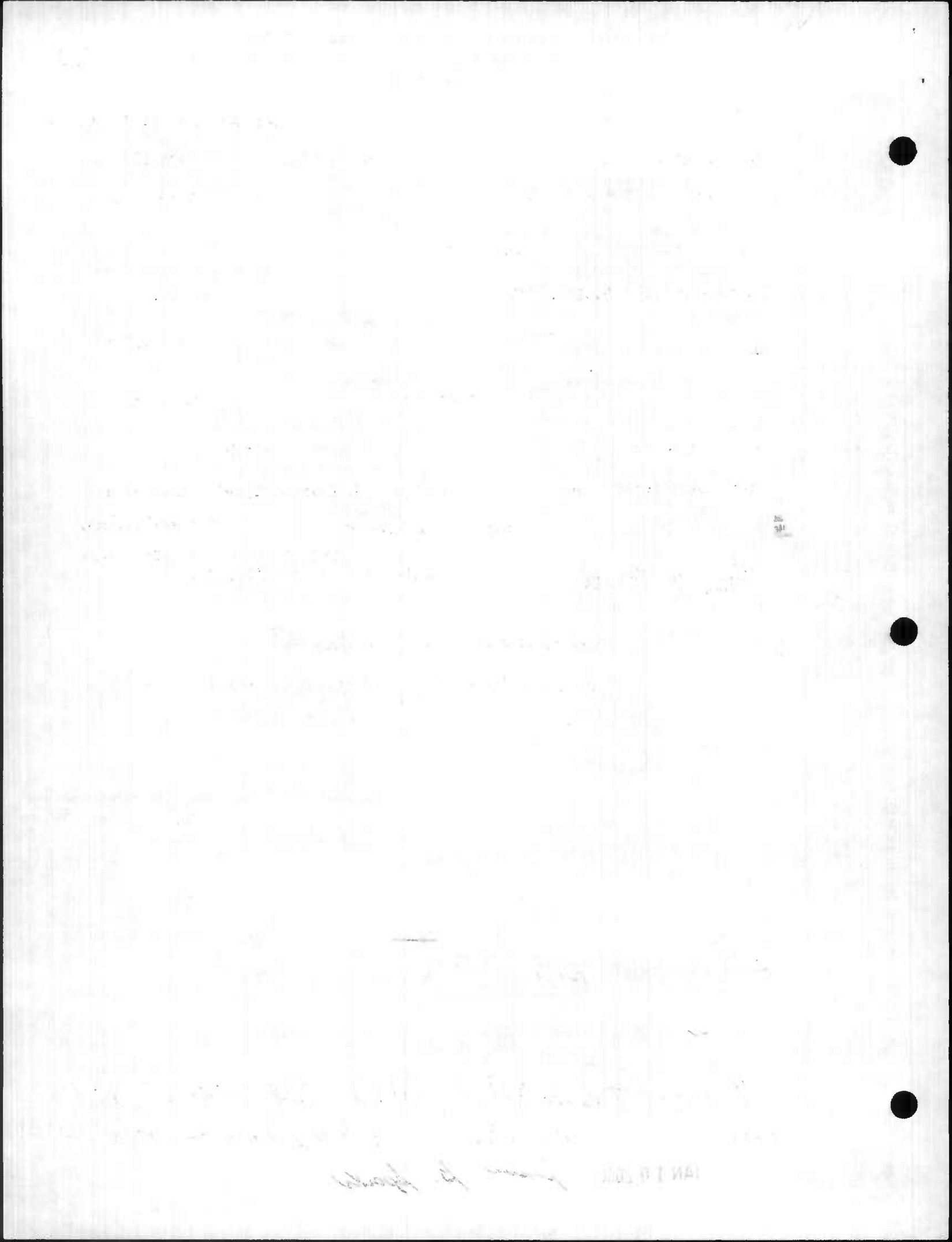
Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42829

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kenesaw Mountain LANDIS						2. Date of Death Month Day Year Dec. 30, 1999		3. Time of Death 10:30 AM	
	4a. Facility Name (If not institution, give street and number) 808 Geis Circle						4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 218-24-7936		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 5, 1928		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 225 Fricks Crossing Road				10f. Zip Code 21550		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic/Welder			16b. Kind of Business/Industry Truck Repair		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Elvin						18. Mother's Name (First, Middle, Maiden Surname) Mamie Florence Wright			
	19a. Informant's Name/Relationship (Type, Print) Gretchen Decker/Step-daughter						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7260 Montevideo Road, Jessup, Maryland 20794			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Omega Crematory		20c. Date 1/8/2000		20d. Location - City or Town, State Morgantown, WV			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Metastatic Carcinoma Unknown Primary Due to (or as a consequence of):								Approximate Interval Between Onset and Death 1 yr.	
	b. Due to (or as a consequence of):									
	c. Due to (or as a consequence of):									
	d. Due to (or as a consequence of):									
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number 031557		29d. Date signed (Month, Day, Year) January 3, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell A. Decker, 1600 S. Cecil Highway, Ste 603, Glen Burnie, Md. 21061										
31. Date filed (Month, Day, Year) JAN - 7 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42830

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leona Frances Mundy				2. Date of Death Month Day Year 12-23-1999				3. Time of Death 10:10 pm	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing Center				4b. City, Town, or Location of Death Rockville				4c. County of Death	
Funeral Director	5. Social Security Number 227-74-1323		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) 11-22-1913		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent									
10a. State MD		10b. County		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 9701 Medical Center Dr.				10f. Zip Code 20850		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Albert W. Miller				18. Mother's Name (First, Middle, Maiden Surname) Rebecca Zigler						
19a. Informant's Name/Relationship (Type, Print) Clara N. Layman				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Ave., Luray, Va. 22835						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Linville UCC Ceme.		Date 12/27/99		20c. Location - City or Town, State Linville, Va.		
21. Signature of Funeral Service Licensee Charles E Owen (sft)				22. Name and Address of Facility Lindsey Funeral Homes, Inc. 473 S. Main St. Harrisonburg, Va. 22801						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Coronary artery disease Due to (or as a consequence of):										YRS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Cardiac Pacemaker Due to (or as a consequence of):										YRS
c. Hypothyroid Due to (or as a consequence of):										YRS
d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier K. G. Rao MD				29c. License number D35792			29d. Date signed (Month, Day, Year) DECEMBER, 24, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SWAROD, G. RAO; 50, W. EDMONSTON DR, ROCKVILLE, MD.										
31. Date filed (Month, Day, Year) JAN 28 2000		32. Registrar's Signature Geneva S Sparks								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL

Carroll County
Court House
Jefferson



1911-1912

1911-1912

1911-1912

1911-1912

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42831

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carol Welteroth Marvin				2. Date of Death Month Day Year December 30, 1999		3. Time of Death 9:05 PM	
	4a. Facility Name (If not institution, give street and number) 2003 Gresham Lane				4b. City, Town, or Location of Death Davidsonville		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 139-50-8688		6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 45 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 10, 1954	9. Birthplace (State or Foreign Country) West Virginia
	Usual Residence of Decedent							
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Davidsonville		10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 2003 Gresham Lane				10f. Zip Code 21035		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Principal		16b. Kind of Business/Industry St. Mary's of the Assum		
17. Father's Name (First, Middle, Last) Carl R. Welteroth				18. Mother's Name (First, Middle, Maiden Surname) Alice Klingengerger				
19a. Informant's Name/Relationship (Type, Print) Charels R. Marvin, Jr (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2003 Gresham Lane, Davidsonville, Maryland 21035				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Renal Cell Carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how Injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D17207		29d. Date signed (Month, Day, Year) 01/11/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David S. Ettinger, MD, 600 N. Wolfe St., 147, Baltimore, MD 21287								
31. Date filed (Month, Day, Year) JAN 13 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Handwritten signature

ORIGINAL

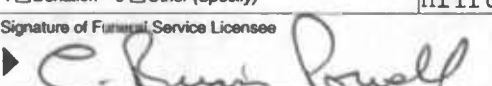
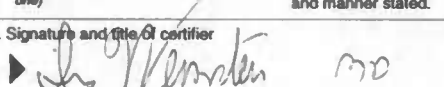
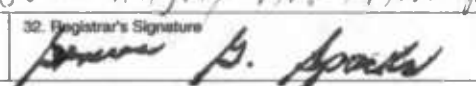
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42832

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Alice Georgina Manz				2. Date of Death Month Day Year December 30 1999				3. Time of Death 11:25 AM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 077-18-9804		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) April 20, 1924		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 12 Bristol Drive				10f. Zip Code 21401		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			15b. Kind of Business/Industry Own home		
	17. Father's Name (First, Middle, Last) George Garrett				16. Mother's Name (First, Middle, Maiden Surname) Alice Corbett					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Edwin H. Manz / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Bristol Drive Annapolis, MD. 21401					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Memorial Gardens		Date 1-3-00		20c. Location - City or Town, State Annapolis, MD.	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St, Annapolis, MD. 21401					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>intracerebral bleed</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D38445		29d. Date signed (Month, Day, Year) Dec 30, 1999			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ice V. K. K. K. 600 R. R. Ave. Annapolis, MD 21401									
State Registrar	31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 69760,

JAN 9 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42833

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARGARET PIPER				2. Date of Death Month 12 Day 25 Year 99		3. Time of Death 1348	
	4a. Facility Name (If not institution, give street and number) Univ. of Maryland Medical System				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 220-32-8400		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 3-1-1938	9. Birthplace (State or Foreign Country) VIRGINIA
	Usual Residence of Decedent				10c. City, Town or Location DOVER		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State DELA.		10b. County KENT		10e. Street and Number 200 NORWICH WAY		10f. Zip Code 19901		10g. Citizen of What Country? UNITED STATES
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry HOME		
17. Father's Name (First, Middle, Last) GEORGE COPES				18. Mother's Name (First, Middle, Maiden Summa) LOLA MAE TAYLOR				
19a. Informant's Name/Relationship (Type, Print) PAULETTE BOWE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 NORWICH WAY, DOVER DELAWARE 19901				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ODD FELLOW CEMETARY		20c. Location - City or Town, State 12-31- MILFORD DE.		20d. Date		
21. Signature of Funeral Service Licensee D. Carson E. Gough				22. Name and Address of Facility YOUNG'S FUNERAL HOMES INC. 309 NORTH ST. MILFORD DE. 19963				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. SEPSIS Due to (or as a consequence of): c. Renal Failure Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Paul Gordon Clark		29c. License number P 11958		29d. Date signed (Month, Day, Year) 12-25-99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul G. Clark 22 South Green St. BALH. MD.								
31. Date filed (Month, Day, Year) JAN 28 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42834

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Michael T. Shivers

2. Date of Death
Month Day Year
DECEMBER 28, 19993. Time of Death
10:23AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral
Director5. Social Security Number
576-90-76436. Sex
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)
35 Yrs.If Under 1 Year
Months DaysIf Under 24 Hrs.
Hours Min.8. Date of Birth
(Month, Day, Year)
March 25, 19649. Birthplace (State or Foreign
Country)
Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

615 63rd Place

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.
Specify: Black15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Stock Clerk16b. Kind of Business/Industry
Private

17. Father's Name (First, Middle, Last)

Harvey Shivers

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Felder

19a. Informant's Name/Relationship (Type, Print)

Harvey Shivers/ Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

615 63rd Pl. Seat Pleasant, Md. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Harmony Memorial Park

Date

1/4/00

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Alexander S. Pope Funeral Homes
5538 Marlboro Pike/Forestville, Md. 2074723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)a. Sepsis
Due to (or as a consequence of):Approximate
Interval Between
Onset and Death

24°

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Lastb. Pneumonia
Due to (or as a consequence of):

24°

c. _____
Due to (or as a consequence of):d. _____
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R Shumacher MD 2309 Shiversfield Rd Wheaton MD 20902

31. Date filed (Month, Day, Year)

JAN 1 2 2000

32. Registrar's Signature

Betina B. Apant

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten signature

00055 I MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42835

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

AMY SMITH

2. Date of Death

12 28 99

3. Time of Death

0330 AM

4a. Facility Name (If not institution, give street and number)

Catonsville Commons Nursing Home

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral
Director

5. Social Security Number

357 07 2309

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/04/1919

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10e. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3004 North Ridge Road #803

10f. Zip Code

21043

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Vernon Haag

18. Mother's Name (First, Middle, Maiden Surname)

Eulalie Greene

19a. Informant's Name/Relationship (Type, Print)

Sandra J. Gill (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4103 Beechwood Road, University Park MD 20782

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

12/31/99

20c. Location - City or Town, State

Alexandria VA

21. Signature of Funeral Service Licensee

Melanie Wilhelm Hagoner

22. Name and Address of Facility

Advent Funeral & Cremation Services
Falls Church VA 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Acute CVA

b.

Due to (or as a consequence of):

HTN

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Approximate Interval Between Onset and Death

1 week

Yr.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Advanced Alzheimer's type 2 dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Turakhia

29c. License number

D36942

29d. Date signed (Month, Day, Year)

12/30/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. TURAKHIA, MD, 1009, Frederick Rd. CATONSVILLE, MD 21228

State
Registrar

31. Date filed (Month, Day, Year)

JAN 04 2000

32. Registrar's Signature

B. Turakhia

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

1973
7-15

1973 7 15

1973 7 15

1973 7 15

1973 7 15

AMEND ITEMS: #23 PART I, 27 PER MEO G780

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2-3-2000 WR

Certificate of Death

Reg. No.

99 42836

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) John Parker Thacker		2. Date of Death Month Day Year DECEMBER 26, 1999		3. Time of Death 20:50 PM	
4a. Facility Name (If not institution, give street and number) 3210 POWDER MILL ROAD		4b. City, Town, or Location of Death		4c. County of Death PRINCE GEORGES	
5. Social Security Number 420-28-4959	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	8. Date of Birth (Month, Day, Year) 11/9/1925		9. Birthplace (State or Foreign Country) Alabama
Usual Residence of Decedent					
10a. State MD	10b. County Prince Georges	10c. City, Town or Location Adelphi		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 3210 Powder Mill Road		10f. Zip Code 20783		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Station Manager	
16b. Kind of Business/Industry U.S. Postal Service		17. Father's Name (First, Middle, Last) John William Thacker		18. Mother's Name (First, Middle, Maiden Surname) Tina Foutain	
19a. Informant's Name/Relationship (Type, Print) Shaun Cox/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 Ridge Road #2 Greenbelt, Maryland 20770			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Highland Cemetery		20c. Location - City or Town, State 12/30/99 Bessemer Alabama	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number OCME		29d. Date signed (Month, Day, Year) DECEMBER 27, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wayne D. McKee 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) JAN 28 2000		32. Registrar's Signature 			

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42837

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley Mae Wose						2. Date of Death Month Day Year December 25, 1999		3. Time of Death 5:30 AM		
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center						4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 070-32-7857		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 59		8. Date of Birth (Month, Day, Year) August 27, 1940		9. Birthplace (State or Foreign Country) New York		
	Usual Residence of Decedent										
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location California				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 23429 Kingston Creek Road				10f. Zip Code 20619		10g. Citizen of What Country? U S A					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Retail Sales				
17. Father's Name (First, Middle, Last) Francis Tyrrell						18. Mother's Name (First, Middle, Maiden Surname) Vivian Weston					
19a. Informant's Name/Relationship (Type, Print) Forest Lee Wose						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20619 23429 Kingston Creek Road, California, Maryland					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date 12/31/1999		20c. Location - City or Town, State Leonardtown, Maryland				
21. Signature of Funeral Service Licensee Michael K. Gardiner						22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Cardiopulmonary Failure Due to (or as a consequence of): b. Kretzfeld-Jakob Syndrome Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death hrs 5 MB	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier James P. Jarboe M.D.				29c. License number D 06419		29d. Date signed (Month, Day, Year) 12/30/99		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe M.D. Hollywood, Maryland 20636											
31. Date filed (Month, Day, Year) JAN 04 2000			32. Registrar's Signature B. Sparks								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **99 42838**
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marie Sloan Wirt				2. Date of Death Month December Day 31 , Year 1999		3. Time of Death 21:39	
	4a. Facility Name (If not Institution, give street and number) 45651 Spruce Drive				4b. City, Town, or Location of Death Lexington Park		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 157-16-6252		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 12, 1923	9. Birthplace (State or Foreign Country) New Jersey
	Usual Residence of Decedent							
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 45651 Spruce Drive				10f. Zip Code 20653		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry N/A		
17. Father's Name (First, Middle, Last) George B. Sloan					18. Mother's Name (First, Middle, Maiden Surname) Elsie Tucker			
19a. Informant's Name/Relationship (Type, Print) Robert T. Wirt / Son					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45718 Military Lane, Great Mills, Maryland 20634			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		Data 1-7-00		20c. Location - City or Town, State Arlington, Virginia	
21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052					22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div> <p>immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p>a. VENTRICULAR Fibrillation</p> <p>Due to (or as a consequence of):</p> <p>b. Diabetes mellitus</p> <p>Due to (or as a consequence of):</p> <p>c. COR. ARTERY DISEASE</p> <p>Due to (or as a consequence of):</p> <p>d. Hyperlipidemia</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p>15 MINS</p> <p>5+ YR</p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier V.K. Shah, M.D.					29c. License number D23634		29d. Date signed (Month, Day, Year) 6 January 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V.K. Shah, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636								
31. Date filed (Month, Day, Year) JAN 06 2000			32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42839

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN WOOD				2. Date of Death Month Day Year Dec. 30 1999				3. Time of Death 10:20 AM					
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel					
Funeral Director	5. Social Security Number 216-32-0754		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 100 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) May 23, 1899		9. Birthplace (State or Foreign Country) Rhode Island	
	Usual Residence of Decedent													
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. Street and Number 2204 River Crescent Drive				10f. Zip Code 21401				10g. Citizen of What Country? USA						
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWI		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Metallurgist				16b. Kind of Business/Industry Civil Service						
17. Father's Name (First, Middle, Last) John W. Wood						18. Mother's Name (First, Middle, Maiden Surname) Ella Weaver								
19a. Informant's Name/Relationship (Type, Print) Bettie A. Wood/ Daughter inlaw						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 River Crescent Dr. Annapolis, Md. 21401								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Bluff Cemetery		Date 01-04-00		20c. Location - City or Town, State Annapolis, Maryland						
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Md. 21401								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. STREPTOCOCCAL SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 4 DAYS														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? N/A 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) N/A		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier 						29c. License number D39037			29d. Date signed (Month, Day, Year) 12-30-99					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOUGLAS S MITCHELL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS														
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

0005. A D 400.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended Item#2 perPhyG780 2/3/2000 EW

99 42840

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) June Angela GREENE						2. Date of Death Month Dec. Day 29 Year 1999		3. Time of Death 12:25 p.m.	
	4a. Facility Name (If not Institution, give street and number) Clearview Nursing Home						4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
Funeral Director	5. Social Security Number 215-20-7899		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 73 Yrs.		8. Date of Birth (Month, Day, Year) June 23 1926		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland			10b. County Washington			10c. City, Town or Location Hagerstown			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 729 Maryland Avenue						10f. Zip Code 21740		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Credit Dept. Clerk		16b. Kind of Business/Industry Retail		
17. Father's Name (First, Middle, Last) Raymond N. Fowler						18. Mother's Name (First, Middle, Maiden Surname) Emma Dulany				
19a. Informant's Name/Relationship (Type, Print) Gary Greene - Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 Brinker Drive #202 Hagerstown, Md. 21740				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery			Date 1/4/2000		20c. Location - City or Town, State Hagerstown, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Bronchopneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 4 Days										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia of Alzheimer's Type										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number D07857		29d. Date signed (Month, Day, Year) Dec. 29, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edson Moody, M.D. 1190 Mt. Aetna Road Hagerstown, Md. 21740										
31. Date filed (Month, Day, Year) DEC 30 1999			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42841

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jeffrey Robert Goell</i>				2. Date of Death Month <i>November</i> Day <i>26</i> Year <i>1999</i>		3. Time of Death <i>7:45 P.M.</i>	
	4a. Facility Name (If not institution, give street and number) <i>51 E. Patrick St.</i>				4b. City, Town, or Location of Death <i>Frederick</i>		4c. County of Death <i>Frederick</i>	
Funeral Director	5. Social Security Number <i>388-56-9463</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>46</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>May 31, 1953</i>	
	9. Birthplace (State or Foreign Country) <i>Wisconsin</i>		10a. State <i>Md.</i>		10b. County <i>Frederick</i>		10c. City, Town or Location <i>Frederick</i>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>51 E. Patrick St.</i>		10f. Zip Code <i>21701</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Editor</i>		16b. Kind of Business/Industry <i>Trade Association</i>			
	17. Father's Name (First, Middle, Last) <i>Robert W. Goell</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Laverne Lauer</i>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Caroline M. Goell (Wife)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>51 E. Patrick St. Frederick, Md. 21701</i>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Smithsburg Crematory Nov. 29, 1999</i>		20c. Location - City or Town, State <i>Smithsburg, Md.</i>		21. Signature of Funeral Service Licensee <i>Dennis L. Davis</i>	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <i>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Cardiac pulmonary failure</i> Due to (or as a consequence of): <i>Advanced cancer of unknown primary</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death <i>Acute</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>WALKMANK</i>		29c. License number <i>MD 53177</i>		29d. Date signed (Month, Day, Year) <i>JAN 14, 2000</i>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>John Walkmank Beckville, MD.</i>		31. Date filed (Month, Day, Year) <i>FEB 04 2000</i>					
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>Sparks</i>		33. Date of Death <i>November 26, 1999</i>					
	34. Time of Death <i>7:45 P.M.</i>		35. County of Death <i>Frederick</i>					

WRC

99-7202-033

UNK.99-299

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42842

Milton A. Johnson

amend item 5, 200 per fh G780 2/3/00 yg

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Milton E. Johnson

2. Date of Death

Month Day Year
DECEMBER 01, 1999

3. Time of Death

9:45 AM.

4a. Facility Name (If not institution, give street and number)

13116 6th. STREET

4b. City, Town, or Location of Death

BOWIE

4c. County of Death

Prince George's

Funeral
Director

5. Social Security Number

215-60-8344
UNKNOWN

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)
June 15, 1953

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8716 Maple Avenue

10f. Zip Code

20715

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

James W. Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Frances Turner

19a. Informant's Name/Relationship (Type, Print)

Mr. James W. Johnson, Jr. (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8716 Maple Avenue Bowie, Maryland 20715

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Fort Lincoln Cemetery
Harmony Memorial Park

Date

1/8/2000
1/11/2000

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rollins Funeral Home, Inc.
4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Smoke Inhalation
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):c.
Due to (or as a consequence of):d.
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

AT

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation
2 ☒ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

11/30/99

28b. Time of Injury

2330 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Victim of house fire

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Abandoned House

28f. Location (Street and Number or Rural Route Number, City or Town, State)

13116 6th St. Bowie, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 02, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. LARON LOCKE MD

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

FEB 03 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 20a,b,c, per fh G780 2/3/00 yg

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42843

22

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hyung Ji				2. Date of Death Month Day Year December 31, 1999				3. Time of Death 5:00 PM		
	4a. Facility Name (If not institution, give street and number) Millenium Nursin Home N.W.				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A		
Funeral Director	5. Social Security Number 213-06-0991		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) Jan 10, 1911		9. Birthplace (State or Foreign Country) N. Korea		
	Usual Residence of Decedent										
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 4601 Pall Mall Road				10f. Zip Code 21215		10g. Citizen of What Country? Korea					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife			16b. Kind of Business/Industry own home				
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown							
19a. Informant's Name/Relationship (Type, Print) Millenium Nursin Home				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4601 Pall Mall Rd Baltimore, MD 21215							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date 2/2/2000		20c. Location - City or Town, State Baltimore, MD					
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Fink Funeral Home 426 Crain Highway Glen Burnie, Md 21061							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Stroke Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dementia Diabetic Mellitus										Approximate Interval Between Onset and Death 1 day 1 yr	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Diabetic Mellitus										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier M. R. Korman MD				29c. License number D25044		29d. Date signed (Month, Day, Year) 1/26/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. R. Korman MD 2717 Hawthorne Rd Baltimore, MD 21227											
31. Date filed (Month, Day, Year) FEB 03 2000		32. Registrar's Signature Benita B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42844

Amended item#28a,29c perPHYG780 2/3/2000 FW

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GRACE POWERS				2. Date of Death Month Day Year DECEMBER 24, 1999		3. Time of Death 12:12 PM		
	4a. Facility Name (If not institution, give street and number) Sacred Heart Hospital				4b. City, Town, or Location of Death Cumberland		4c. County of Death Allegheny		
Funeral Director	5. Social Security Number 213-16-9536		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Sept 30, 1918		
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Allegheny		10c. City, Town or Location Cumberland		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 57 Jackson Street		10f. Zip Code 21539		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. white Specify:			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife		16b. Kind of Business/Industry own home		17. Father's Name (First, Middle, Last) John S. Leake		18. Mother's Name (First, Middle, Maiden Surname) Maude M. Winters	
19a. Informant's Name/Relationship (Type, Print) Sacred Heart Hospital				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Seaton Drive, Cumberland, MD 21502					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 3 years		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) Dec 24, 1999		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number D36766		29d. Date signed (Month, Day, Year) DECEMBER 24, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIKRAMADITYA POONAI M.D. 920 NATIONAL HWY. CUMBERLAND, MD. 21502				31. Date filed (Month, Day, Year) FEB 03 2000				32. Registrar's Signature [Signature]	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item#24a.26.27 perPhyG780 2/3/2000 EW

Reg. No. 99 42845

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last)

Claude Suggs

2. Date of Death
Month Day Year
December 19, 19993. Time of Death
12:20 PM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

246-14-7025

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 26, 1924

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State
MD10b. County
N/A10c. City, Town or Location
Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2512 E. Monumnet Street

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: unknown13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

unknown

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

Johns Hopkins Hospital

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

600 N. Wolfe Street Baltimore, MD 21213

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☒ Other (Specify) in state20b. Place of Disposition (Name of
cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

e. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

98 N. BROADWAY BALTO. MD 21231

31. Date filed (Month, Day, Year)

FEB 03 2000

32. Registrar's Signature

James P. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42846

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS TAYLOR

2. Date of Death

Month Day Year
December 26, 1999

3. Time of Death

12:01 A.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

254-40-9609

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year
October 14, 1928

9. Birthplace (State or Foreign)

South Carolina

Usual Residence of Decedent

10a. State

D.C.

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

850 21st Street, N.E. Apt. #7

10f. Zip Code

20002

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laundress

16b. Kind of Business/Industry

Yales Laundry (Retired)

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Magdaline Davis

19a. Informant's Name/Relationship (Type, Print)

Mr. Joseph T. Taylor (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

850 21st Street, N.E. Apt. #7 Washington, D.C. 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematorium, or other place)

Forest Hills Memorial Gardens

Date

12/30/99

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

Sarah C. Henderson

22. Name and Address of Facility

Rottnis Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

b. SUDDEN DEATH

Due to (or as a consequence of):

c. ASYSTOLE

Due to (or as a consequence of):

d. ASPIRATION. (Pneumonia)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anil K. Mahajan MD

29c. License number

D50689

29d. Date signed (Month, Day, Year)

12/26/1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANIL K. MAHAJAN PGHOSPITAL ED. 3001 HOSPITAL DRIVE MD 20985

31. Date filed (Month, Day, Year)

FEB 03 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42847

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JULIA I. BROOKE				2. Date of Death Month DECEMBER Day 21 , Year 1999		3. Time of Death 7:47 PM	
	4a. Facility Name (If not Institution, give street and number) LAUREL REGIONAL HOSPITAL				4b. City, Town, or Location of Death LAUREL		4c. County of Death PRINCE GEORGE'S	
Funeral Director	5. Social Security Number 579-34-3365		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 26, 1929	9. Birthplace (State or Foreign Country) WASHINGTON DC
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location WALDORF			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 729 UNIVERSITY DRIVE				10f. Zip Code 20602		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME	
17. Father's Name (First, Middle, Last) JOHN F. REARDON, SR.				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE E. LANGLEY				
19a. Informant's Name/Relationship (Type, Print) FRANK E. BROOKE, SR. - SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29721 BRICH CIRCLE, MECHANICSVILLE, MD 20659				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) RESURRECTION CEMETERY		20c. Location - City or Town, State 12/29/99 CLINTON, MARYLAND		
21. Signature of Funeral Service Licensee  MARK G. BROHAWN M00053				22. Name and Address of Facility THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. RESPIRATORY FAILURE Due to (or as a consequence of): b. METASTATIC CARCINOMA LUNG Due to (or as a consequence of): c. CHRONIC OBSTRUCTIVE DISEASE Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OVARY						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. Signature and title of certifier 		29g. License number D19220		29d. Date signed (Month, Day, Year) DECEMBER 22, 1999		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEIL A. MEADE, MD 9811 MALLARD DRIVE LAUREL, MARYLAND 20708								
31. Date filed (Month, Day, Year) FEB 03 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

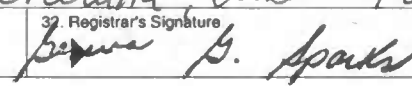
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42848

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LeRoy Clinton Bonser						2. Date of Death Month Day Year December 27 1999		3. Time of Death 12:05 PM	
	4a. Facility Name (If not institution, give street and number) ATRIA SALISBURY						4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 207-05-6221		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 23, 1918		9. Birthplace (State or Foreign Country) PENNSYLVANIA	
	Usual Residence of Decedent									
10a. State DELAWARE		10b. County SUSSEX		10c. City, Town or Location MILLVILLE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 129 MAIN STREET						10f. Zip Code 19970		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FOREMAN			16b. Kind of Business/Industry STEEL PRODUCTION			
17. Father's Name (First, Middle, Last) OTTIWELL J. BONSER						18. Mother's Name (First, Middle, Maiden Surname) EMMA F. SLIKER				
19a. Informant's Name/Relationship (Type, Print) PATRICIA L. O'BOYLE/DAUGHTER						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1007, OCEAN VIEW, DELAWARE 19970				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) BETHLEHEM MEM. PARK CEM.		Date 1/8/00		20c. Location - City or Town, State BETHLEHEM, PA		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ca Esophagus Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Teens Years										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number 028769		29d. Date signed (Month, Day, Year) 12/28/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas N. Borodulia and Flewirth Island, DE 19944										
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42849

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS LEROY COLLINS				2. Date of Death Month 12 Day 23 Year 99		3. Time of Death 9:40 PM							
	4a. Facility Name (If not institution, give street and number) RES. 309 MORRIS STREET				4b. City, Town, or Location of Death FREIGHTLAND		4c. County of Death WICOMICO							
Funeral Director	5. Social Security Number 216-38-9124		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 10-8-41	9. Birthplace (State or Foreign Country) MARYLAND						
	Usual Residence of Decedent													
10e. State MD		10b. County WICOMICO		10c. City, Town or Location FREIGHTLAND		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No								
10e. Street and Number 309 MORRIS STREET				10f. Zip Code 21826		10g. Citizen of What Country? USA								
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: AKRO AMERICAN								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER		16b. Kind of Business/Industry SOMERSET COUNTY RDR.								
17. Father's Name (First, Middle, Last) EDWARD M. COLLINS SR				18. Mother's Name (First, Middle, Maiden Surname) SARAH E. ARMISTEAD COLLINS										
19a. Informant's Name/Relationship (Type, Print) SHARON ELIZABETH HOLBROOK				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 MORRIS ST. FREIGHTLAND MARYLAND 21801										
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) SPRING HILL CEMETERY		20c. Location - City or Town, State 1/3/99 ALBANY MD.								
21. Signature of Funeral Service Licensee John A. Prince				22. Name and Address of Facility BENJIE SMITH 7/H 917 W. ISABELLA ST. SALISBURY MD.										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
<table border="1"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a. MYOCARDIAL INFARCTION</td> <td rowspan="4"> Due to (or as a consequence of): b. CORONARY ART. DISEASE c. d. </td> <td rowspan="4"> Approximate Interval Between Onset and Death MINUTO 1-2 mos. </td> </tr> <tr><td></td></tr> <tr><td></td></tr> <tr><td></td></tr> </table>								Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. MYOCARDIAL INFARCTION	Due to (or as a consequence of): b. CORONARY ART. DISEASE c. d.	Approximate Interval Between Onset and Death MINUTO 1-2 mos.			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. MYOCARDIAL INFARCTION	Due to (or as a consequence of): b. CORONARY ART. DISEASE c. d.	Approximate Interval Between Onset and Death MINUTO 1-2 mos.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LUNG CANCER REP. FAILURE RENAL INSUFFICIENCY						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No												
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred										
28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier Dr. [Signature]				29c. License number D44069		29d. Date signed (Month, Day, Year) 12-30-99								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. CURRAN, MD 106 MILFORD #605 SALISBURY MD 21807														
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature [Signature]										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

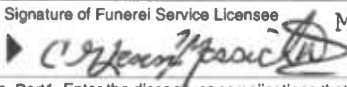


To Be Completed by Funeral Director

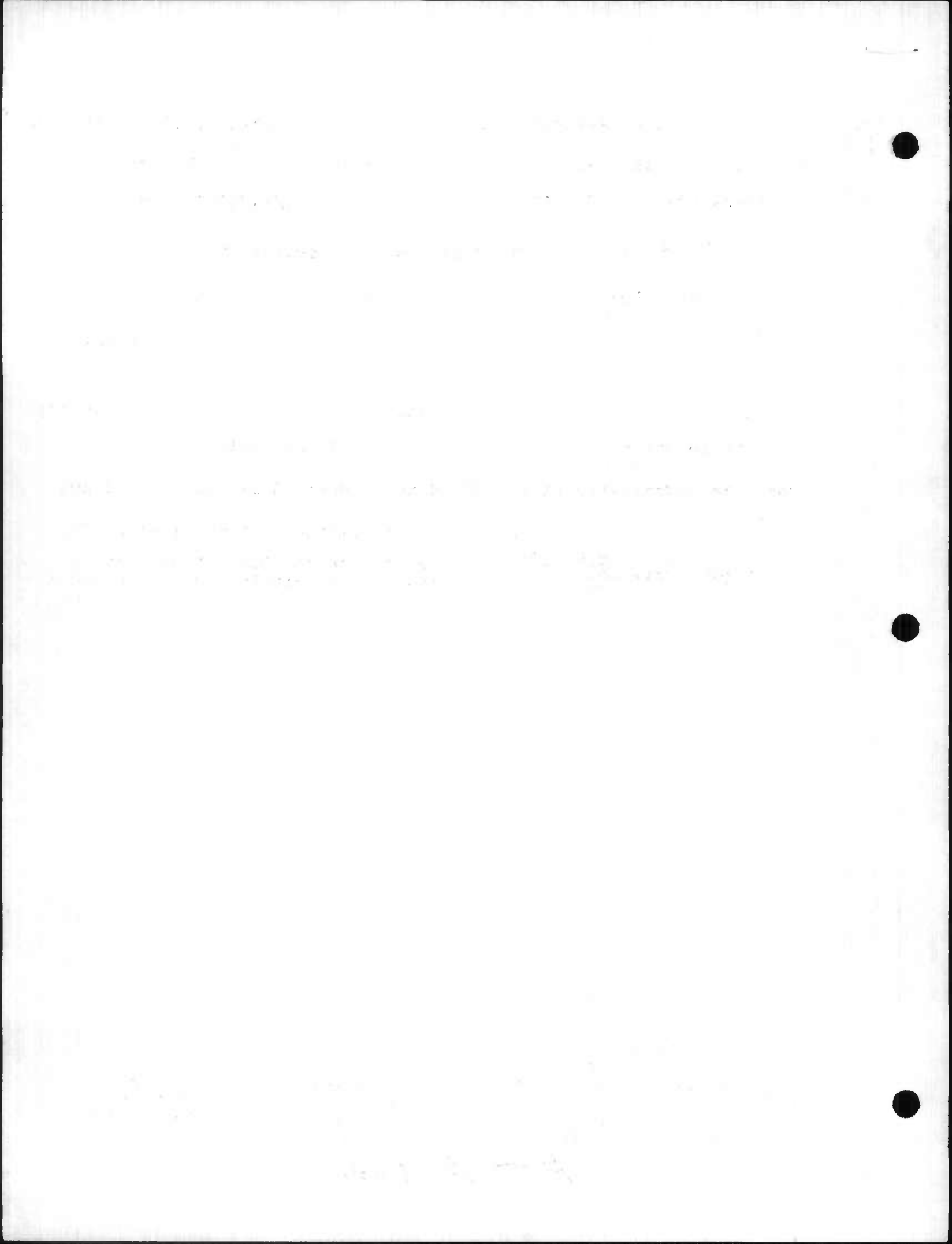
Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENDED: 24a No State of Maryland / Department of Health and Mental Hygiene
25 Yes WCHD bbk 1/6/2000 Certificate of Death

Reg. No. 99 42850

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOVANNIA FRANCES DASHIELL				2. Date of Death Month 12 Day 31 Year 1999		3. Time of Death 11: A.M.		
	4e. Facility Name (If not institution, give street and number) 3515 Texas Road				4b. City, Town, or Location of Death Bivalve		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 220-32-2045		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) 5/14/1936		
	9. Birthplace (State or Foreign Country) Md.		10a. State Md.		10b. County Wicomico		10c. City, Town or Location 3515 Texas Road - Bivalve, Md.		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 3515 Texas Road		10f. Zip Code 21814		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Coldwater Seafood		16b. Kind of Business/Industry Seafood Industry		17. Father's Name (First, Middle, Last) Bernard James		18. Mother's Name (First, Middle, Maiden Surname) Ola Dashiell	
19a. Informant's Name/Relationship (Type, Print) Roscelle McNealy, Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Harden Court, Salisbury, Md. 21802		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Elsey Church Cemetery 1-6-00 Bivalve, Md.		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Messick Funeral Home, P.O. Box 61 Bivalve, Md. Bivalve, Maryland 21814		23a. Pertinent disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Anteromedial wall Heart Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D 37670		29d. Date signed (Month, Day, Year) 01/04/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. L. H. Evangelista 105 Pine Bluff Road #4 Salisbury, MD 21801	
31. Data filed (Month, Day, Year) JAN 06 2000		32. Registrar's Signature 		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020			



Reg. No. 99 4285

Reg. No.

99 4285

DHHM 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42852

Physician (Medical Examiner)	1. Decedent's Name (First, Middle, Last) Patsy A. Hull				2. Date of Death Month: 12, Day: 29, Year: 1999				3. Time of Death 9:20 PM		
	4a. Facility Name (If not institution, give street and number) 9025 Star Road				4b. City, Town, or Location of Death Delmar				4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 213-44-2284		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) 9/6/1945		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State MD		10b. County Wicomico		10c. City, Town or Location Delmar				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 9025 Star Road				10f. Zip Code 21875				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry own Home			
17. Father's Name (First, Middle, Last) Willis Truitt				18. Mother's Name (First, Middle, Maiden Surname) Kathryn T. Bradford							
19a. Informant's Name/Relationship (Type, Print) Ronald M. Hull Sr. / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9025 Star Road Delmar, Maryland 21875							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens		20c. Date 1/5/00		20d. Location - City or Town, State Hebron, Maryland			
21. Signature of Funeral Service Licensee Keith R. Hawley				22. Name and Address of Facility Holloway Funeral Home, Salisbury, Md.							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) s. Metastatic Breast Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 3 yrs	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier				29c. License number D26278				29d. Date signed (Month, Day, Year) 12-30-99			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID COLLINS MD 145 E. Carroll St. Salisbury, MD 21801											
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State Registrar

Certificate of Death

Reg. No.

99 42853

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley A Myers

2. Date of Death

Month Day Year
Dec 21 1999

3. Time of Death

6:31PM

4a. Facility Name (If not institution, give street and number)

Memorial Hospital

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

Funeral
Director

5. Social Security Number

219-56-8165

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
Dec. 20, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

WV

10b. County

Morgan

10c. City, Town or Location

Paw Paw

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

P. O. Box 202

10f. Zip Code

25434

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)
12

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Household

17. Father's Name (First, Middle, Last)

Edward Seed Ryan

18. Mother's Name (First, Middle, Maiden Surname)

Georgia Smith

19a. Informant's Name/Relationship (Type, Print)

Michael Myers/husband husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 202 Paw Paw, WV 25434

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Camp Hill Cemetery

Date

12/24/99

20c. Location - City or Town, State

Paw Paw, WV

21. Signature of Funeral Service Licensee

Frealey-Kimble

22. Name and Address of Facility

Frealey-Kimble Funeral Home
Paw Paw, West Virginia

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular fibrillation

1 1/2 hrs

Due to (or as a consequence of):

b. Arteriosclerotic heart disease

Uk

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation
2 ☐ Accident 6 ☐ Could not be determined
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul Snow

29c. License number

D 09157

29d. Date signed (Month, Day, Year)

Dec 21 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Snow, M.D. 124 W 3rd St Cumberland Md 21502

31. Date filed (Month, Day, Year)

JAN 24 2000

32. Registrar's Signature

Benjamin B Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42854

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Virgie Martin

2. Date of Death
Month Day Year
DECEMBER 30, 19993. Time of Death
1:30 P.M.

4a. Facility Name (If not institution, give street and number)

Berlin Nursing & Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral
Director

5. Social Security Number

213-24-1114

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
March 4, 1903

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Berlin

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10522 Griffin Rd.

10f. Zip Code

21811

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Families

17. Father's Name (First, Middle, Last)

John P. Briddell

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Fassett

19a. Informant's Name/Relationship (Type, Print)

Brenda A. Jarmon/granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10522 Griffin Rd., Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

St. Pauls Cemetery

Date

1/5/00

20c. Location - City or Town, State

Berlin, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lewis N. Watson Funeral Home
1618 West Rd., Salisbury, MD 2180123a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. PNEUMONIA -

Due to (or as a consequence of):

b. INFLUENZA -

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

2 Day -

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, well, etc -

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide28a. Date of Injury
(Month, Day Year)28b. Time of
Injury28c. Injury at
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

12/31/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

410-641-4400

State
Registrar

31. Date filed (Month, Day, Year)

JAN 05 2000

32. Registrar's Signature

Beverly B. Sparks

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

MARTIN, VIRGIE

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42855

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD WALTON METZ				2. Date of Death Month Day Year December 31, 1999		3. Time of Death 3:30 PM	
	4a. Facility Name (If not Institution, give street and number) 1016 E. Schumaker Manor Dr.				4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 217-36-2310		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) July 19, 1939	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1016 E. Schumaker Manor Dr		10f. Zip Code 21804		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Army		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plant Manager		16b. Kind of Business/Industry Pepsi Cola Co.				
17. Father's Name (First, Middle, Last) Ralph Hillary Metz				18. Mother's Name (First, Middle, Maiden Surname) Katie Turney				
19a. Informant's Name/Relationship (Type, Print) Larry A. Whitt/Life Partner				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1016 E. Schumaker Manor Dr., Salisbury, MD				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 1/4/00		20c. Location - City or Town, State Salisbury, MD		
21. Signature of Funeral Service Licensee Keith R. Downey				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer induced Emaciation 1 month Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D-052520		29d. Date signed (Month, Day, Year) 1/03/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIKAS BAJPAI M.D. Tilghman Rd, Salisbury MD								
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature [Signature]						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

30+IVA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42856

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Donnelly Brady				2. Date of Death Month Day Year December 31, 1999		3. Time of Death 2:25 pm	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital				4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George	
Funeral Director	5. Social Security Number 126-01-3974		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Oct 05, 1918	
	9. Birthplace (State or Foreign Country) New York		10a. Usual Residence of Decedent 10e. State MD		10b. County Prince George		10c. City, Town or Location Laurel	
10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 407 5th Street		10f. Zip Code 20707		10g. Citizen of What Country? USA		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman		16b. Kind of Business/Industry Building Industry				
17. Father's Name (First, Middle, Last) John J. Brady				18. Mother's Name (First, Middle, Maiden Surname) Alice Donnelly				
19a. Informant's Name/Relationship (Type, Print) Esther Brady /spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 5th Street, Laurel, Maryland 20707				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		20c. Date 1/6/00		20d. Location - City or Town, State Laurel, Maryland		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Congestive Heart Failure Due to (or as a consequence of): b. Severe emphysema Due to (or as a consequence of): c. Chronic Atrial Fibrillation Due to (or as a consequence of): d. Multiple infarct dementia								
23b. Part 2. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. urosepsis						23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
24a. Was an autopsy performed? 1 Yes 2 No						24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year) 1/6/00		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State) 14201 Laurel Park Dr Laurel MD 20707				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D13671		29d. Date signed (Month, Day, Year) 1/03/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B.G. MANEJWALA 14201 Laurel Park Dr Laurel MD 20707								
31. Date filed (Month, Day, Year) JAN 04 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director
To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item@ \$B,0% PERPhyG780 2/9/2000 EW

Certificate of Death

Reg. No. 99 42857

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) BABY BOY		2. Date of Death Month December Day 5 Year 99		3. Time of Death 8:20 PM	
4a. Facility Name (If not institution, give street and number) Harbor Hospital Center		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
5. Social Security Number None	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) Yrs.	If Under 1 Year Months 3 Days 23	8. Date of Birth (Month, Day, Year) Dec 3 99	9. Birthplace (State or Foreign Country) Maryland
Usual Residence of Decedent		10a. State MD		10b. County Howard	10c. City, Town or Location Columbia
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 5613 Harpers Farm Road		10f. Zip Code 21044	10g. Citizen of What Country? United States
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Infant College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None	
16b. Kind of Business/Industry none		17. Father's Name (First, Middle, Last) David Oppor		18. Mother's Name (First, Middle, Maiden Surname) Catherine French	
19a. Informant's Name/Relationship (Type, Print) Catherine French/mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5613 Harpers Farm Road Columbia, MD 21044			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) in state		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Fetal anomalies Due to (or as a consequence of): b. Kidney disease Due to (or as a consequence of): c. Prematurity Due to (or as a consequence of): d.					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Erica Collins		29c. License number M32011		29d. Date signed (Month, Day, Year) December 8th 1999	
30. Name and address of person who completed cause of death (item 23a) (Type, Print) Erica Collins 3001 S Hanover Street					
31. Date filed (Month, Day, Year)		32. Registrar's Signature Erica Collins			

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42858

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Edward Holt				2. Date of Death Month December Day 30 Year 1999		3. Time of Death 3:40 am	
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 403-36-0821		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) Mar 06, 1930	
	9. Birthplace (State or Foreign Country) Oklahoma		10a. State MD		10b. County Howard		10c. City, Town or Location Highland	
Usual Residence of Decedent		10d. Inside City Limits 1 Yes 2 No		10e. Street and Number 7173 Mink Hollow Road		10f. Zip Code 20777		
10g. Citizen of What Country? USA		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No		
14. Race - American Indian, Black, White, etc. White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry United States Government		
17. Father's Name (First, Middle, Last) Ray Leslie Holt				18. Mother's Name (First, Middle, Maiden Surname) Margaret McGee				
19a. Informant's Name/Relationship (Type, Print) Lenore Holt /spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7173 Mink Hollow Road, Highland, Maryland 20777				
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem		20c. Location - City or Town, State 1/4/00 Crownsville, Maryland		20d. Date		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Anoxic Brain Injury Due to (or as a consequence of): Respiratory Failure Due to (or as a consequence of): Meningitis Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
23c. Approximate Interval Between Onset and Death 2 wks								
23d. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No								
23e. Were eulogies performed? 1 Yes 2 No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Congestive Heart Failure								
25. Was case referred to medical examiner? 1 Yes 2 No		26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number DS1908		29d. Date signed (Month, Day, Year) December 30 1999				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David Magliano MD 18111 Prince Phillip Drive Suite 327 Olney, Maryland								
31. Date filed (Month, Day, Year) JAN 04 2000		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

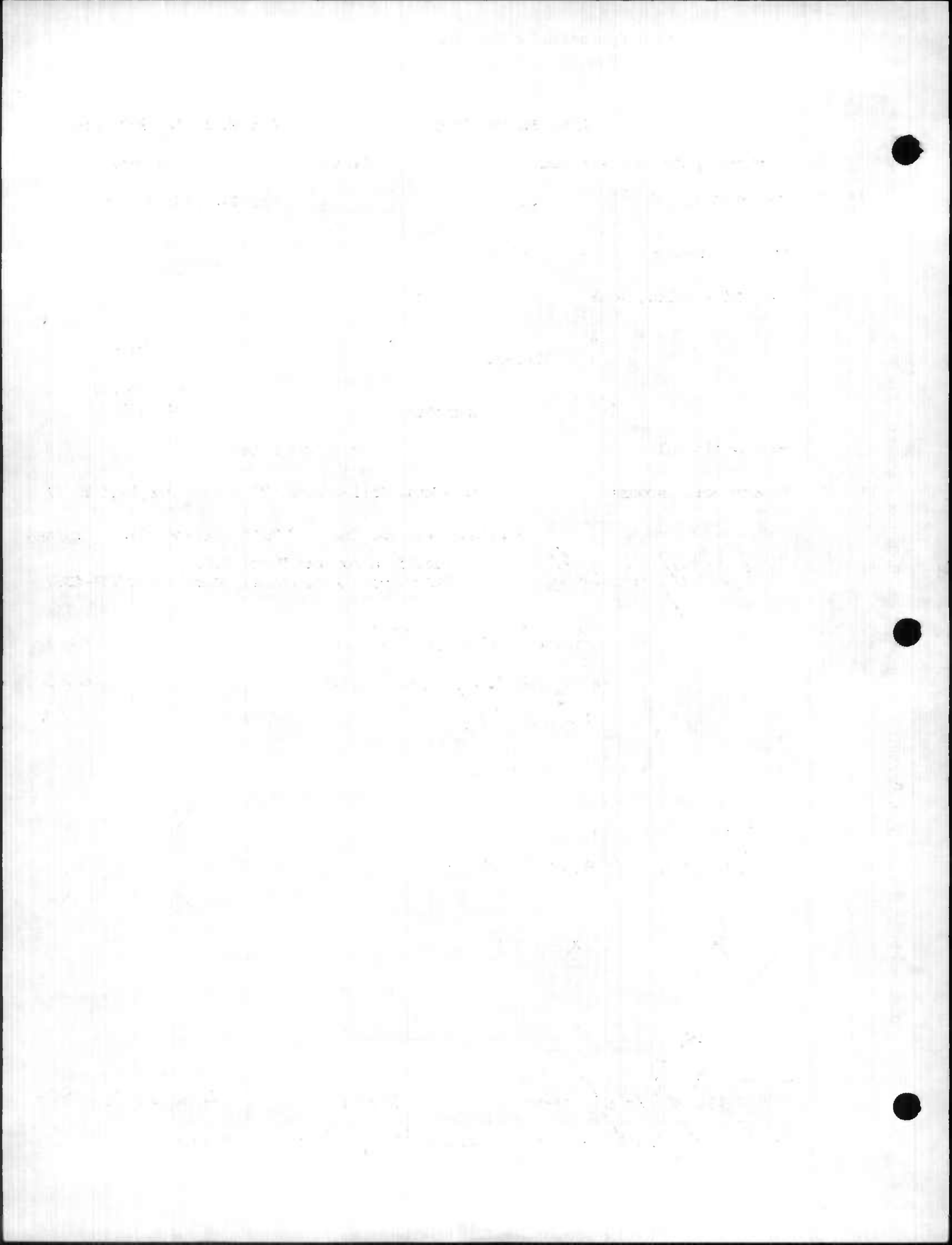
Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42859

Amended Item#11,23a perPhyG780 2/9/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>JANERIO MURPHY</i>				2. Date of Death Month <i>12</i> Day <i>28</i> Year <i>1999</i>		3. Time of Death <i>7:30 PM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Prince George Hospital Center</i>				4b. City, Town, or Location of Death <i>Cheverly</i>		4c. County of Death <i>Prince Georges</i>	
Funeral Director	5. Social Security Number <i>NONE</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. _____	If Under 1 Year Months _____ Days _____	If Under 24 Hrs. Hours _____ Min. _____	8. Date of Birth (Month, Day, Year) <i>DEC. 28, 1999</i>	9. Birthplace (State or Foreign Country) <i>MARYLAND</i>
	Usual Residence of Decedent							
10a. State <i>MD</i>		10b. County <i>Prince Georges</i>		10c. City, Town or Location <i>FORT WASHINGTON</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>2700 SHAWN COURT</i>				10f. Zip Code <i>20744</i>		10g. Citizen of What Country? <i>U. S. A</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>INFANT</i> College (14 or 5+) <i>INFANT</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>INFANT</i>			16b. Kind of Business/Industry <i>INFANT</i>	
17. Father's Name (First, Middle, Last) <i>WARREN MURPHY III</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ANDREA CARTERS CHOATE MURPHY</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Prince Georges Hospital Center</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3001 HOSPITAL DRIVE CHEVERLY MD 20785</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <i>PRINCE GEORGE HOSP</i>				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>PGHC</i>		20c. Date <i>12/28/99</i>		20d. Location - City or Town, State <i>CHEVERLY MD</i>
21. Signature of Funeral Service Director <i>Joseph Deckerly</i>				22. Name and Address of Facility <i>PGHC 3001 HOSPITAL DRIVE CHEVERLY MD 20785</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Prematurity Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Prematurity</i>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M _____		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Willie McCloud</i>		29c. License number <i>021140</i>		29d. Date signed (Month, Day, Year) <i>DEC. 28, 1999</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Willie McCloud MD 3001 HOSPITAL DRIVE CHEVERLY MD 20785</i>								
31. Date filed (Month, Day, Year) <i>FEB 09 2000</i>				32. Registrar's Signature <i>Benita A. Spence</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "Natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42860

Amended Item#20bperHOSP, #29d perPhyG780 2/9/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NOAH TWINA				2. Date of Death Month 7 Day 12 Year 99		3. Time of Death 0100	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number NONE		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 1 Months 2 Days 0		8. Date of Birth (Month, Day, Year) 7-12-99	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Frederick		10c. City, Town or Location Mount Airy	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 13403 Bottom Road		10f. Zip Code 21771		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INFANT		16b. Kind of Business/Industry INFANT		17. Father's Name (First, Middle, Last) Richard Noah		
18. Mother's Name (First, Middle, Maiden Surname) Angela R. Stiffler		19a. Informant's Name/Relationship (Type, Print) Angela Noah		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13403 Bottom Rd Mount Airy, md. 21771		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) Shady Grove Adventist		20c. Date 9/23/99		20d. Location - City or Town, State Rockville, md.		21. Signature of Funeral Service Licensee Heather Brown		
22. Name and Address of Facility Shady Grove Adventist		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Extreme Prematurity		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Sheri Hamersley MD		
29c. License number 50787		29d. Date signed (Month, Day, Year) 1/26/2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheri Hamersley MD 9901 Medical Center Dr. Rockville, md. 20850		31. Date filed (Month, Day, Year) FEB 09 2000		
32. Registrar's Signature Beverly S. Spaw		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Amended Item#20bperHosp, #29d perPhyG780 2/9/2000 EW

Certificate of Death

Reg. No.

99 42861

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

NOAH TWIN B

2. Date of Death

Month

Day

Year

3. Time of Death

0100

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

NONE

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

7-12-99

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Mount Airy

10d. Inside City Limits

2 ☒ Yes 2 ☐ No

10e. Street and Number

13403 Bottom Road

10f. Zip Code

21771

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INFANT

16b. Kind of Business/Industry

INFANT

17. Father's Name (First, Middle, Last)

Richard Noah

18. Mother's Name (First, Middle, Maiden Surname)

Angela R. Stiffler

19a. Informant's Name/Relationship (Type, Print)

Angela Noah

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13403 Bottom Road Mount Airy, Md. 21771

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Shady Grove Adventist

Date

9-23-99

20c. Location - City or Town, State

Rockville, Md.

21. Signature of Funeral Service Licensee

Deborah Shroeth

22. Name and Address of Facility

Shady Grove Adventist

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Extreme Prematurity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sheri L. Hamersley MD

29c. License number

50787

29d. Date signed (Month, Day, Year)

1/26/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sheri Hamersley MD 9901 Medical Center Dr. Rockville, Md 20850

31. Date filed (Month, Day, Year)

FEB 09 2000

32. Registrar's Signature

Benjamin S. Spitzer

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42862

Amended Item#20b perFHG780 2/9/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) NICOLAS GARETH NEELY		2. Date of Death Month September Day 6 Year 1999		3. Time of Death 03:46
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital		4b. City, Town, or Location of Death Rockville		4c. County of Death MONTGOMERY COUNTY
Funeral Director	5. Social Security Number INFANT	6. Sex 1 M 2 F	7. Age (In yrs. last birthday) 11	8. Date of Birth (Month, Day, Year) August 25, 1999	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Montgomery	10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 Yes 2 No
	10e. Street and Number 1305 MIMOSA LANE		10f. Zip Code 20904		10g. Citizen of What Country? USA
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
	14. Place - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INFANT		16b. Kind of Business/Industry INFANT		
	17. Father's Name (First, Middle, Last) William Neely		18. Mother's Name (First, Middle, Maiden Surname) Nicole Neely		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Nicole Neely		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1305 MIMOSA LANE Silver Spring, Md. 20904		
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Shady Grove Adventist		20c. Date 3-6-2000
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Debra Howard		22. Name and Address of Facility Shady Grove Adventist		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. EXTREME PREMATUREITY Due to (or as a consequence of): PSEUDOMONAS SEPSIS Due to (or as a consequence of): DISSEMINATED INTRAVASCULAR COAGULOPATHY Due to (or as a consequence of): NECROTIZING ENTEROCOLITIS		Approximate Interval Between Onset and Death 11 DAYS 3 DAYS 3 DAYS		
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		24a. Was an autopsy performed? 1 Yes 2 No		
	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		25. Was case referred to medical examiner? 1 Yes 2 No		
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)		27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, lecture, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Terri D. Fazio MD		29c. License number 50453		29d. Date signed (Month, Day, Year) SEPTEMBER 6, 1999
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terri D. Fazio MD 9901 Medical Center Dr. Rockville Md. 20850				
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) FEB 09 2000		32. Registrar's Signature [Signature]		
	33. Registrar's Title [Signature]				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

99 42863

Amended Item#25,27 perPhyG780 2/9/2000 EW

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thelma O. Rottler						2. Date of Death Month December Day 27 , Year 1999		3. Time of Death 4:45 AM												
	4a. Facility Name (If not institution, give street and number) Lorien Columbia Nursing Home						4b. City, Town, or Location of Death Columbia		4c. County of Death Howard												
Funeral Director	5. Social Security Number 216-09-4809		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 95 Yrs.		8. Date of Birth (Month, Day, Year) May 9, 1904		9. Birthplace (State or Foreign Country) MD												
	Usual Residence of Decedent																				
10a. State MD		10b. County Howard		10c. City, Town or Location Columbia				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
10e. Street and Number 6334 Cedar Lane				10f. Zip Code 21044			10g. Citizen of What Country? USA														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white													
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) housewife			16b. Kind of Business/Industry own-home														
17. Father's Name (First, Middle, Last) unknown						18. Mother's Name (First, Middle, Maiden Surname) Silvia Wastler															
19a. Informant's Name/Relationship (Type, Print) Thelma Milter/friend						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5565 Montgomerychurch Rd, Greencastle PA 17225															
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		20c. Location - City or Town, State Baltimore, MD 21201		20d. Date													
21. Signature of Funeral Service Licensee Ronald S. Wade, Director						22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201															
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Senile dementia</td> <td>Approximate Interval Between Onset and Death 10 years</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. Senile dementia	Approximate Interval Between Onset and Death 10 years	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):			
Immediate Cause (Final disease or condition resulting in death)	a. Senile dementia	Approximate Interval Between Onset and Death 10 years																			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																				
	c. Due to (or as a consequence of):																				
	d. Due to (or as a consequence of):																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown													
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred													
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																					
29b. Signature and title of certifier P. L. Poblete				29c. License number D50338			29d. Date signed (Month, Day, Year) Jan. 6, 2000														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11055 Little Patuxent Parkway Columbia MD 21044, P.O. L. Poblete																					
31. Date filed (Month, Day, Year) FEB 09 2000				32. Registrar's Signature Benjamin S. Sparks																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#15,16a-b,17 perKBG780 2/9/2000 EW **Certificate of Death**

Reg. No.

99 42864

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Baby girl Ross

2. Date of Death
Month Day Year
November 13, 1999

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

Saint Agnes Health Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral
Director

5. Social Security Number

N/A

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11-12-99

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4011 Walrad Street

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: Black

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4or 5+)

0

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Infant

16b. Kind of Business/Industry

Infant

17. Father's Name (First, Middle, Last)

Michael Theodore Bennett

18. Mother's Name (First, Middle, Maiden Surname)

Pamela L. Ross

19a. Informant's Name/Relationship (Type, Print)

Pamela L. Ross (mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4011 Walrad St. Baltimore Md 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Saint Agnes Health Care

Date

May 2000

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Cathy Berg per A. Lewis Saint Agnes HealthCare 900 Caton Ave Baltimore Md 21229

22. Name and Address of Facility

Md 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. respiratory failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5.5 hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. severe hyaline membrane disease

Due to (or as a consequence of):

11 hours

c. extreme prematurity

Due to (or as a consequence of):

11 hours

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

bilateral pneumothorax

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Susan M. Schapiro MD neonatologist

29c. License number

D24590

29d. Date signed (Month, Day, Year)

November 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan M. Schapiro MD, Saint Agnes Health Care, 900 Caton Avenue, Baltimore MD 21229

31. Date filed (Month, Day, Year)

FEB 09 2000

32. Registrar's Signature

[Signature]

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Baby Girl Ross

Division of Vital Records, P.O. Box 68760,

1875

Journal of the

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

LEONARD
STOUTAMEND ITEMS: #23 PART I, 27 PER MEO
Certificate of Death

Reg. No.

99 42865

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Leonard Franklin Stout III		2. Date of Death Month DECEMBER Day 31 Year 1999		3. Time of Death 1:50P.M.
	4a. Facility Name (If not institution, give street and number) 1514 S. PHILADELPHIA BLVD		4b. City, Town, or Location of Death ABERDEEN		4c. County of Death HARFORD
Funeral Director	5. Social Security Number 216-90-5430	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months 0 Days 0	If Under 24 Hrs. Hours 0 Min. 0
	8. Date of Birth (Month, Day, Year) July 9, 1967		9. Birthplace (State or Foreign Country) Pennsylvania		
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Cecil 10c. City, Town or Location Elkton		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 427 Booth Street		10f. Zip Code 21921		10g. Citizen of What Country? United States
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Manager		16b. Kind of Business/Industry Apartment Complex		
	17. Father's Name (First, Middle, Last) Leonard F. Stout, Jr.		18. Mother's Name (First, Middle, Maiden Surname) Kathy Kornafelt		
	19a. Informant's Name/Relationship (Type, Print) Frances C. Stout/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 427 Booth Street, Elkton, Maryland 21921		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) North East Methodist Cem.		20c. Location - City or Town, State 1/5/00 North East, Maryland
Physician /Medical Examiner	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHRONIC NARCOTISM Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. _____				
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				
State Registrar	28a. Date of Injury (Month, Day Year) 1/5/00		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how injury occurred At home, term, street, factory, office building, etc. (Specify)		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JANUARY 1, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TITUS M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) FEB 09 2000		32. Registrar's Signature 			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42866

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phyllis Ann Webster						2. Date of Death Month Day Year December 31, 1999		3. Time of Death 11:15 am	
	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital						4b. City, Town, or Location of Death Laurel		4c. County of Death Prince George	
Funeral Director	5. Social Security Number 096-32-6166		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Jul 21, 1939		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
10a. State MD		10b. County Prince George		10c. City, Town or Location Laurel				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 6403 Forest Mill Lane				10f. Zip Code 20707			10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5+ College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teacher			16b. Kind of Business/Industry Special Education			
17. Father's Name (First, Middle, Last) Edward H. Potter						18. Mother's Name (First, Middle, Maiden Surname) Alice O'Hare				
19a. Informant's Name/Relationship (Type, Print) Donald Webster /spouse						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6403 Forest Mill Lane, Laurel, Maryland 20707				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Columbia Memorial Park			Date 1/5/00		20c. Location - City or Town, State Columbia, Maryland		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. Metastatic renal cell carcinoma Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
Approximate Interval Between Onset and Death 24 hours 3 months										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 						29c. License number D23743		29d. Date signed (Month, Day, Year) January 01, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Martin D. Weltz 7525 Greenway Center Drive, Greenbelt, Maryland 20770										
31. Date filed (Month, Day, Year) JAN 04 2000			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42867

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARLON D. McCOY

2. Date of Death

Month Day Year
DECEMBER 29, 1999

3. Time of Death

4:30 am

4a. Facility Name (If not institution, give street and number)

12302 PERCIL LN.

4b. City, Town, or Location of Death

UPPER MARLBORO

4c. County of Death

PRINCE GEORGES

Funeral
Director

5. Social Security Number

578-13-5184

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

26 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
JAN 6, 1973

9. Birthplace (State or Foreign Country)

KANSAS

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12302 PERCIL LANE

10f. Zip Code

20772

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Maurice Richardson

18. Mother's Name (First, Middle, Maiden Surname)

Laura McCoy

19a. Informant's Name/Relationship (Type, Print)

Laura McCoy-Barbee/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12302 Percil Ln. Upper Marlboro, Md. 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

Date

1/6/00

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee

Keith A. Savage M1085

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Disseminate Mycobacterium Infection*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

29 Dec 99

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Bruce Greenberg CPT MC

29c. License number

D-52191

29d. Date signed (Month, Day, Year)

Jan 06 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce Greenberg WHAMC 6900 Georgia Ave NW Washington DC 20307-5001

31. Date filed (Month, Day, Year)

JAN 12 2000

32. Registrar's Signature

*Anne B. Smith*State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

George A. ...

DOCS 8 E MAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42868

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE DEXTER STERLING				2. Date of Death Month Day Year DECEMBER 11 1999		3. Time of Death 1307	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 218 48 6608	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6-1-48		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Fruitland		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 110 Williams Ave.				10f. Zip Code 21826		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (14 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry Seafood Industry			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Jacob Kilraine Sterling				18. Mother's Name (First, Middle, Maiden Surname) Eutha Mae Sterling			
	19a. Informant's Name/Relationship (Type, Print) Constance Sterling/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Williams Ave., Fruitland, MD 21826			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens		Date 12/15/99		20c. Location - City or Town, State Hebron, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. MORBID OBESITY Due to (or as a consequence of): c. OBESITY HYPOVENTILATION SYNDROME Due to (or as a consequence of): d. HYPERTENSION						Approximate Interval Between Onset and Death 3 DAYS YEARS YEARS YEARS	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D2498C		29d. Date signed (Month, Day, Year) 12/13/99	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert J. Reilly, M.D. 560 Riverside Dr. Salisbury, MD 21801							
	31. Date filed (Month, Day, Year) FEB 10 2000				32. Registrar's Signature 			

99-7773-510

cm

Unknown 99-326

George William Banadio

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42869

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GEORGE WILLIAM BANADIO				2. Date of Death Month Day Year December 25, 1999				3. Time of Death 6:00 A.M.					
	4a. Facility Name (If not institution, give street and number) University of Maryland Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A					
Funeral Director	5. Social Security Number unknown		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Aug 22, 1959		9. Birthplace (State or Foreign Country) unknown	
	Usual Residence of Decedent													
10a. State unknown		10b. County unknown		10c. City, Town or Location unknown				10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No unknown						
10e. Street and Number unknown				10f. Zip Code unknown				10g. Citizen of What Country? unknown						
11. Marital Status unknown <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates unknown		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown College (1-4 or 5+) unknown				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unknown				16b. Kind of Business/Industry unknown						
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown										
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201										
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place) in state		Date		20c. Location - City or Town, State								
21. Signature of Funeral Service Licensee Joseph B. Van Sant				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death)														
a. Fatty Liver And Pneumonia Due to (or as a consequence of):														
b. Complicated By Hypothermia Due to (or as a consequence of):														
c. Due to (or as a consequence of):														
d. Due to (or as a consequence of):														
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No												26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 12/24/99		28b. Time of Injury 4:24P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject Exposed To Cold						
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street				28f. Location (Street and Number or Rural Route Number, City or Town, State) 200 S. Howard Street Baltimore, Md.								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier Theodore M. King M.D.				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) December 26, 1999						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201														
31. Date filed (Month, Day, Year) FEB 14 2000		32. Registrar's Signature Benjamin B. Sparks												

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician
/Medical
Examiner

Funeral
Director

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) KELLIE Mae ALMONEY				2. Date of Death Month Day Year DECEMBER 15 1999		3. Time of Death 3:38p.m.			
4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death Baltimore			
5. Social Security Number 165-62-1054		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov 24, 1965 Pa.			
Usual Residence of Decedent									
10a. State Pa		10b. County York		10c. City, Town or Location York		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 1024 W. Poplar St.				10f. Zip Code 17404		10g. Citizen of What Country? U.S.A.			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry NONE			
17. Father's Name (First, Middle, Last) Ronald E Helfrich				18. Mother's Name (First, Middle, Maiden Surname) Shirley A Frey					
19a. Informant's Name/Relationship (Type, Print) Brian Almoney Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1024 W Poplar St. York Pa 17404					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Susquehanna Memorial Gardens Dec 18, 1999		Date Dec 18, 1999		20c. Location - City or Town, State York Pa			
21. Signature of Funeral Service Licensee KAREN ILGENFRIZ				22. Name and Address of Facility JJ Hartenstein Mortuary 24 Second St New Freedom, Pa 17349 822 E Market St York Pa 17403					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Match unrelated Bone Marrow Transplant Due to (or as a consequence of): d. Myelodysplasia								Approximate Interval Between Onset and Death 17 days 17 days 27 days 5 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier Yiping Yang, M.D.				29c. License number D0054582		29d. Date signed (Month, Day, Year) December, 15, 1999			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yiping Yang, M.D. Johns Hopkins Oncology center									
31. Date filed (Month, Day, Year) FEB 11 2000		32. Registrar's Signature B. Sparks							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42871

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TINASHA MONIA MASON						2. Date of Death Month Day Year AUG. 18, 1999			3. Time of Death 13:39 PM		
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER						4b. City, Town, or Location of Death CHEVERLY			4c. County of Death PRINCE GEORGES		
Funeral Director	5. Social Security Number NONE		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days 3		8. Date of Birth (Month, Day, Year) AUG. 18, 1999		9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent						10a. State MARYLAND		10b. County PRINCE GEORGES		10c. City, Town or Location LANDOVER	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						10e. Street and Number 7725 BURNSIDE ROAD		10f. Zip Code 20785		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) NONE NONE				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NONE - INFANT				16b. Kind of Business/Industry NONE - INFANT			
	17. Father's Name (First, Middle, Last) KENAN DORRELL MASON						18. Mother's Name (First, Middle, Maiden Surname) NICOLE LEE RAWLINSON					
	19a. Informant's Name/Relationship (Type, Print) PRINCE GEORGES HOSPITAL CTR.						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) PGHC		Date 2-9-00		20c. Location - City or Town, State CHEVERLY MD			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility PGHC 3001 HOSPITAL DRIVE, CHEVERLY, MD					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. PREMATURITY Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
	Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):											
	c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NON VIABILITY								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 26819		29d. Date signed (Month, Day, Year) 2/9/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDUL G. CHAUDRY, 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785												
31. Date filed (Month, Day, Year) FEB 17 2000				32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42872

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eddie Rorie		2. Date of Death Month Day Year December 28, 1999		3. Time of Death 10:17pm
	4a. Facility Name (If not institution, give street and number) Sinai Hospital of Baltimore		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 211-69-5258	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 50	8. Date of Birth (Month, Day, Year) June 23, 1948	9. Birthplace (State or Foreign Country) NC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 5122 Arbutus Avenue		10f. Zip Code 21215		10g. Citizen of What Country? USA
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) unknown		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unemployed		16b. Kind of Business/Industry N/A		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) unk		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Sellers		
	19a. Informant's Name/Relationship (Type, Print) Doris Gamble-Foster Sister		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5122 Arbutus Avenue., Balto., MD 21215		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 1/3/2000 Baltimore, MD
	21. Signature of Funeral Service Licensee Lewis T. Gwynn per DVR		22. Name and Address of Facility Lewis T. Gwynn Funeral Home 4517 Parkheights Ave., Balto., MD		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Aspiration Pneumonia Due to (or as a consequence of): b. Myocardial Infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 2 days 1 day				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Down's Syndrome					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) M					
28b. Time of Injury M					
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier [Signature]					
29c. License number KES-000					
29d. Date signed (Month, Day, Year) February 15, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Mirechla Minter Sinai Hospital					
31. Date filed (Month, Day, Year) FEB 16 2000					
32. Registrar's Signature [Signature]					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42873

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Girl Agyepong

2. Date of Death

October 27 99

3. Time of Death

05:08

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

INFANT

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

5 October 27, 1999

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

German Town

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

20013 Sweetgum Circle #34

10f. Zip Code

20874

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INFANT

16b. Kind of Business/Industry

INFANT

17. Father's Name (First, Middle, Last)

Eric Agyepong

18. Mother's Name (First, Middle, Maiden Surname)

Athena Ama Dzovor

19a. Informant's Name/Relationship (Type, Print)

Athena Agyepong

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20013 Sweetgum Circle #34 German Town, Md. 20874

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Shady Grove Adventist

Date

11-29-99

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

A. H. H. H.

22. Name and Address of Facility

Shady Grove Adventist

9901 Medical Center Dr

Rockville, Md 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. extreme Cardio-pulmonary insufficiency

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. premature Labor

Due to (or as a consequence of):

c. premature rupture of the membrane

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. H. H. H.

29c. License number

D 12878

29d. Date signed (Month, Day, Year)

02/4/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEN-SHO SENG, MD 9075 Shady Grove Ct. Gaithersburg, Md 20877

State
Registrar

31. Date filed (Month, Day, Year)

FEB 23 2000

32. Registrar's Signature

B. Spake

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

FEB 28 1966

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND#7 PER DVR G788 (10-20-2000 JAB

State of Maryland / Department of Health and Mental Hygiene

AMEND#7&20B PER ROSP. G780 2-24-2000 JAB **Certificate of Death**

Reg. No. **99 42874**

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA-ABI Jallow						2. Date of Death Month Day Year September 28, 1999			3. Time of Death 05:15am			
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital						4b. City, Town, or Location of Death Rockville			4c. County of Death Montgomery			
Funeral Director	5. Social Security Number INFANT		6. Sex 1 M 2 F		7. Age (In yrs. last birthday) Yrs. Months Days 1 10 15		8. Date of Birth (Month, Day, Year) September 26, 1999			9. Birthplace (State or Foreign Country) Md.			
	Usual Residence of Decedent										10d. Inside City Limits 1 Yes 2 No		
10a. State Md		10b. County Montgomery		10c. City, Town or Location Gaithersburg									
10e. Street and Number 18724 Pier Point Pl						10f. Zip Code 20879		10g. Citizen of What Country? USA					
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No			13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No			14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 0						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INFANT			16b. Kind of Business/Industry INFANT				
17. Father's Name (First, Middle, Last) Baboucar Jallow						18. Mother's Name (First, Middle, Maiden Surname) Amie Sowe							
19a. Informant's Name/Relationship (Type, Print) Father						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18724 Pier Point Pl Gaithersburg, md 20879							
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) Shady Grove Adventist			20c. Location - City or Town, State Rockville, Maryland		20d. Date 10/27/99		
21. Signature of Funeral Service Licensee Deborah Howard						22. Name and Address of Facility Shady Grove Adventist							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypoxic Respiratory failure Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown		
											24a. Was an autopsy performed? 1 Yes 2 No		
											24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical examiner? 1 Yes 2 No						26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined						28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 Yes 2 No		28d. Describe how injury occurred	
						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier Hamersley, MD						29c. License number 50787			29d. Date signed (Month, Day, Year) January 18, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheri Hamersley, M.D. 9901 medical Center Dr. Rockville, md. 20850													
31. Date filed (Month, Day, Year) FEB 24 2000						32. Registrar's Signature B. Smith							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42875

Amended Items 29c, 29d, 30 per ME 6779b

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CURTIS L. HARRELL				2. Date of Death Month Day Year DECEMBER 22, 1999				3. Time of Death 12:00pm		
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO		
Funeral Director	5. Social Security Number 246-84-8656		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 48 Yrs.		8. Date of Birth (Month, Day, Year) 2-20-51		9. Birthplace (State or Foreign Country) N.C.		
	Usual Residence of Decedent										
10a. State VA.		10b. County N/A		10c. City, Town or Location NEWPORT NEWS				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 349 ST. THOMAS DRIVE APT. 25B				10f. Zip Code 23606				10g. Citizen of What Country? USA			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: BLACK			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4 or 5+) -4-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TEACHER				16b. Kind of Business/Industry EDUCATION			
17. Father's Name (First, Middle, Last) JOHN T. HARRELL				18. Mother's Name (First, Middle, Maiden Surname) BEATRICE MORRIS							
19a. Informant's Name/Relationship (Type, Print) JOYCE STEWART(SISTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 EAST 129th ST. APT 1-C NEW YORK, N.Y. 10035							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) HILLCREST CEMETERY		Date 12-29-99		20c. Location - City or Town, State WINDSOR, N.C.					
21. Signature of Funeral Service Licensee <i>Janeth D. Hirsner</i>				22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dilated Cardiomyopathy										Approximate Interval Between Onset and Death	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>John Locke MD</i>				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) January 21, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Locke MD 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JAN 21 2000		32. Registrar's Signature <i>Benjamin B. Sparks</i>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7300.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amended Item#23a perPhyG780 2/28/2000 EW

Reg. No. 99 42876

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) C. MARJORIE OWINGS						2. Date of Death Month Day Year December 22, 1999		3. Time of Death 10:25AM																										
	4a. Facility Name (If not institution, give street and number) Roland Park Place						4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A																										
Funeral Director	5. Social Security Number 526-32-2200		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) January 6, 1907		9. Birthplace (State or Foreign Country) Maryland																										
	10s. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																												
10e. Street and Number 830 West 40th Street						10f. Zip Code 21211		10g. Citizen of What Country? USA																											
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White																											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical Secretary			16b. Kind of Business/Industry Private Office																										
17. Father's Name (First, Middle, Last) John Hammond Owings						18. Mother's Name (First, Middle, Maiden Surname) Clara Virginia Bushey																													
19a. Informant's Name/Relationship (Type, Print) John B Hull Lawyer						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 East Baltimore Street Suite 901 Baltimore Maryland 21202																													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Reisterstown Meth Church Cem.			Date 12/27/99		20c. Location - City or Town, State Reisterstown, Maryland																											
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212																													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																			
<table border="0"> <tr> <td rowspan="4"> Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last </td> <td>a.</td> <td>Pulmonary Embolus</td> <td>Approximate Interval Between Onset and Death 8 hours</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Deep Venous Thrombosis</td> <td>1 day</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Trauma Fall</td> <td>1 week</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> <td></td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Pulmonary Embolus	Approximate Interval Between Onset and Death 8 hours	Due to (or as a consequence of):			b.	Deep Venous Thrombosis	1 day	Due to (or as a consequence of):			c.	Trauma Fall	1 week		Due to (or as a consequence of):				d.			
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Pulmonary Embolus	Approximate Interval Between Onset and Death 8 hours																																
	Due to (or as a consequence of):																																		
	b.	Deep Venous Thrombosis	1 day																																
	Due to (or as a consequence of):																																		
c.	Trauma Fall	1 week																																	
Due to (or as a consequence of):																																			
d.																																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma Allergies								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred																										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)																											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																			
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number D37133		29d. Date signed (Month, Day, Year) December 22, 1999																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Donna Dow 7600 Osler Drive Towson, Maryland Suite 209																																			
31. Date filed (Month, Day, Year) FEB 28 2000			32. Registrar's Signature <i>[Signature]</i>																																

Baltimore, Maryland 21215-0020
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
 Department of Health and Mental Hygiene.
 Import: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director
 Medical Certification: To Be Completed by Physician/Medical Examiner

James O. H. H. H.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

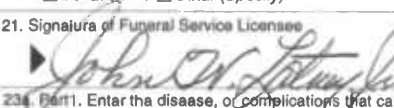
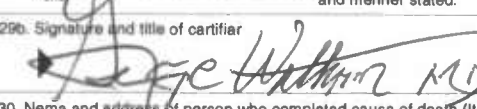
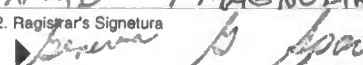
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Alice L. Jamison		2. Date of Death Month Day Year July 25, 1999		3. Time of Death 3:30 AM	
4a. Facility Name (If not Institution, give street and number) Hospice of Charles County		4b. City, Town, or Location of Death LaPlata		4c. County of Death Charles	
5. Social Security Number 578-16-7153	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 91 Yrs.	8. Date of Birth Month Day Year 1/12/1908	9. Birthplace (State or Foreign Country) North Carolina	
Usual Residence of Decedent					
10a. State MD	10b. County Charles	10c. City, Town or Location Waldorf		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 846 Copley Avenue		10f. Zip Code 20602		10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic		16b. Kind of Business/Industry Private			
17. Father's Name (First, Middle, Last) Willie Langford			18. Mother's Name (First, Middle, Maiden Surname) Margaret Kearney Langford		
19a. Informant's Name/Relationship (Type, Print) Sherita Thomas / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 846 Copley Avenue; Waldorf, MD 20602			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		20c. Location - City or Town, State 7/31/99 Brentwood, MD	
21. Signature of Funeral Service Licensee  CC0348		22. Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave NW; Wash., DC 20011			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. METASTATIC OVARIAN CANCER Due to (or as a consequence of): b. CONGESTIVE HEART FAILURE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of): d.					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of injury M	28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  MD		29c. License number D20629		29d. Date signed (Month, Day, Year) 7-27-99	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GEORGE H. WATHEN MD - 1 MAGNOLIA DRIVE - LA PLATA DRIVE MD 20646					
31. Date filed (Month, Day, Year) MAR 03 2000		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State
Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42878

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAMELA ANN RAINS				2. Date of Death Month 12 Day 15 Year 1999		3. Time of Death 450 PM		
	4a. Facility Name (If not institution, give street and number) 304 S. CAMDEN AVE				4b. City, Town, or Location of Death FRUITLAND		4c. County of Death WICOMICO		
Funeral Director	5. Social Security Number 214-68-5685		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 44 Yrs.		8. Date of Birth (Month, Day, Year) 10-9-1995		
	9. Birthplace (State or Foreign Country) MICH.		10a. State MD		10b. County Wicomico		10c. City, Town or Location FRUITLAND		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 304 S. CAMDEN AVE		10f. Zip Code 21826		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CUSTOM AUTO UPHOLSTERY		16b. Kind of Business/Industry AUTOMOTIVE UPHOLSTERY		17. Father's Name (First, Middle, Last) GLENN RUARK SR		18. Mother's Name (First, Middle, Maiden Surname) SADIE HANNSON	
19a. Informant's Name/Relationship (Type, Print) J. R. RAINS HUSBAND		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 S CAMDEN AVE FRUITLAND, MD 21826		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SALISBURY CREMATORY		20c. Location - City or Town, State 12-16-99 SALISBURY, MD	
21. Signature of Funeral Service Licensee C. Henry Proctor		22. Name and Address of Facility MESSICK FUNERAL HOME		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Adenocarcinoma of lung Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 1 year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier James E. Martin, M.D.		29c. License number 030690		29d. Date signed (Month, Day, Year) Feb. 22, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD		31. Date filed (Month, Day, Year) MAR 07 2000		32. Registrar's Signature Denise B. Sparks					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

99 42879

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Shadonna Shanta' Parrott</i>				2. DATE OF DEATH MONTH <i>11</i> DAY <i>07</i> YEAR <i>99</i>		3. TIME OF DEATH <i>1:47 PM</i>	
4. SOCIAL SECURITY NUMBER _____		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. _____		7. DATE OF BIRTH (Month, Day, Year) <i>11-07-99</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MD.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Southern Md. Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Clinton</i>	
9c. COUNTY OF DEATH <i>md.</i>				10a. STATE <i>md.</i>		10b. COUNTY <i>Prince George</i>	
10c. CITY, TOWN OR LOCATION <i>Suitland</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>3605 Pkwy Terrace Drive #3</i>	
10f. ZIP CODE <i>20746</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>N/A</i>		16b. KIND OF BUSINESS/INDUSTRY <i>N/A</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Robert Parrott</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Donna Watson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Donna Watson/Mother</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3605 Parkway Terrace Dr #3, Suitland, MD 20746</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald S. Wade, Director</i>				22. NAME AND ADDRESS OF FACILITY <i>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. severe prematurity</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>N/A</i>			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Miss Y. [Signature]</i>				29c. LICENSE NUMBER <i>R0052970</i>		29d. DATE SIGNED (Month, Day, Year) <i>11/7/99</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Olivia Troganag</i>							
31. DATE FILED (Month, Day, Year) <i>MAR 09 2000</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42880

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernest C. Murray				2. Date of Death Month 6 Day 12 Year 99		3. Time of Death 9:40am	
	4a. Facility Name (If not institution, give street and number) Mariner Health of Southern Maryland				4b. City, Town, or Location of Death Clinton MD.		4c. County of Death Prince George	
Funeral Director	5. Social Security Number 246-03-6006		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 5/20/1910	9. Birthplace (State or Foreign Country) N.C.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD.		10b. County Prince George		10c. City, Town or Location Forrestville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 1904 Altamont Avenue				10f. Zip Code 20747		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Enigneer		16b. Kind of Business/Industry Feb. Government			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Ernest Cleveland Murray				18. Mother's Name (First, Middle, Maiden Surname) Unavailable/Carrie			
	19a. Informant's Name/Relationship (Type, Print) Ernest C. Murray Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Altamont Avenue Forrestville, MD.			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Cemetary		Date 6/17/99		20c. Location - City or Town, State Suitland, MD.	
	21. Signature of Funeral Service Licensee William Latney per DVR				22. Name and Address of Facility Latney Funeral Home 3831 Georgia Avenue, N.W. Washington D.C.			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Old Cardiovascular Accident						Approximate Interval Between Onset and Death 5 years	
	Due to (or as a consequence of): Hypertensive, Coronary Artery Disease						10 years	
	Due to (or as a consequence of):							
	Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Philip L. Calcagno		29c. License number D41540		29d. Date signed (Month, Day, Year) 6 MARCH 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Philip L. Calcagno - Mariner Health - So. Md - Clinton, Md.								
31. Date filed (Month, Day, Year) MAR 09 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#1 PER MD. G781 3-10-2000 JAB

Certificate of Death

Reg. No. 99 42881

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician
/Medical
Examiner

Funeral
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) BABY BOY DEMMEKE				2. Date of Death Month Day Year DECEMBER 6 1999		3. Time of Death 5:15 pm	
4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death	
5. Social Security Number Unknown		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days 10		8. Date of Birth (Month, Day, Year) 12-6-99	
9. Birthplace (State or Foreign Country) MD							
10a. State MD		10b. County		10c. City, Town or Location Silver Spring, MD		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 200 Linton King Heigh				10f. Zip Code 20904		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) N/A N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		16b. Kind of Business/Industry N/A	
17. Father's Name (First, Middle, Last) AFework, ESKinder				18. Mother's Name (First, Middle, Maiden Surname) Tsega Demmeke			
19a. Informant's Name/Relationship (Type, Print) Tsega Demmeke / mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Linton King Heigh - Silver Springs, MD 20904			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Disposal Johns Hopkins Hospital		20c. Location - City or Town, State Baltimore, MD		20d. Date 12/6/99	
21. Signature of Funeral Service Licensee Deborah Evans				22. Name and Address of Facility SHH-600 N. Wolfe St. 21287			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Severe prematurity Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Approximate Interval Between Onset and Death 2 hours							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier Christine Nguyen				29c. License number 05575		29d. Date signed (Month, Day, Year) December 6, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Nguyen Johns Hopkins Hospital 600 N. Wolfe Baltimore, MD 21287							
31. Date filed (Month, Day, Year) MAR 10 2000				32. Registrar's Signature Anna B. Sparks			

1285

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42882

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MANASSES

ANDREWS

2. Date of Death

Month Day Year
DECEMBER 1, 1999

3. Time of Death

10:00 PM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

0

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)
30 DEC. 1, 1999

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2414 PRESTON STREET

10f. Zip Code

21213

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

0

16b. Kind of Business/Industry

0

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

ROSALAND TAYLOR

19a. Informant's Name/Relationship (Type, Print)

ROSALAND TAYLOR (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2414 PRESTON STREET, BALTIMORE, MARYLAND 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

HOLY REDEEMER

Date

4/13/00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ST. JOSEPH MEDICAL CENTER
7601 OSLER DRIVE, TOWSON, MARYLAND 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

PREMATURE RUPTURED MEMBRANES

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHORIOAMNIONITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending
Investigation
2 ☐ Accident 6 ☐ Could not be
determined
3 ☐ Suicide
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 22092

29d. Date signed (Month, Day, Year)

12/14/99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN BERLIN, M.D., 10402 RIDGLAND ROAD, COCKEYSVILLE, MD. 21030

State
Registrar

31. Date filed (Month, Day, Year)

DEC 15 2000

32. Registrar's Signature

Steven Berlin

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42883

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Celia Yavner				2. Date of Death Month Day Year December 29, 1999				3. Time of Death 10:30 am	
	4a. Facility Name (If not institution, give street and number) 4701 Willard Avenue #718				4b. City, Town, or Location of Death Chevy Chase				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 223-52-5429		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 24, 1915		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Chevy Chase				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 4701 Willard Avenue #718				10f. Zip Code 20815		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Rabbi Samuel Wainger				18. Mother's Name (First, Middle, Maiden Surname) Leah Allen					
	19a. Informant's Name/Relationship (Type, Print) Emanuel Yavner - Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 Willard Avenue #718 Chevy Chase, MD 20815					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Forest Lawn Cemetery		20c. Location - City or Town, State 1/2/00 Norfolk, Virginia			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, Virginia 22310					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Distress Due to (or as a consequence of): Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Obstructive Lung Disease									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number D35996		29d. Date signed (Month, Day, Year) March 17, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda Burell, MD 2101 Medical Park Drive Silver Spring, MD									
State Registrar	31. Date filed (Month, Day, Year) MAR 20 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42884

Physician
/Medical
ExaminerFuneral
Director

1. Decedent's Name (First, Middle, Last) Baby Girl Jones						2. Date of Death Month Day Year December 3, 1999			3. Time of Death 1:00 a.m.				
4a. Facility Name (If not institution, give street and number) Sinai Hospital						4b. City, Town, or Location of Death Baltimore			4c. County of Death				
5. Social Security Number N/A		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 1		If Under 1 Year Months Days 40		8. Date of Birth (Month, Day, Year) December 2, 1999		9. Birthplace (State or Foreign Country) Maryland			
Usual Residence of Decedent													
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number 7407 Lexham Court				10f. Zip Code 21244				10g. Citizen of What Country? USA					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A				16b. Kind of Business/Industry N/A					
17. Father's Name (First, Middle, Last) Davon C. Harris						18. Mother's Name (First, Middle, Maiden Surname) Katrina R. Jones							
19a. Informant's Name/Relationship (Type, Print) Katrina R. Jones - Mother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7402 Lexham Court Baltimore, MD 21244							
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Hospital				20b. Place of Disposition (Name of cemetery, crematory or other place) Sinai Hospital		Date 12-6-99		20c. Location - City or Town, State Baltimore, Maryland					
21. Signature of Funeral Service Licensee Disposal 						22. Name and Address of Facility Sinai Hospital 2401 W. Belvedere Ave. Baltimore, MD 21215							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Extreme prematurity Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) N/A		28b. Time of injury N/A		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred N/A					
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) N/A				28f. Location (Street and Number or Rural Route Number, City or Town, State) N/A							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and Title of Certifier 						29c. License number RES000		29d. Date signed (Month, Day, Year) December 3, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tola Omotosho, M.D. Sinai Hospital 2401 W. Belvedere Ave Baltimore, MD 21215													
31. Date filed (Month, Day, Year) MAR 30 2000		32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99-42885

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

UNKNOWN

(99-277)

2. Date of Death

Month

Day

Year

NOVEMBER 16, 1999

3. Time of Death

8:30 P.M.

4a. Facility Name (If not institution, give street and number)

SHOCK TRAUMA CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral
Director

5. Social Security Number

unknown

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

unknown

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

unknown

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

unknown

10b. County

unknown

10c. City, Town or Location

unknown

10d. Inside City Limits

unknown 20 No

10e. Street and Number

unknown

10f. Zip Code

unknown

10g. Citizen of What Country?

unknown

11. Marital Status unknown

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

If Yes, Give Year or Dates: unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Penn Street Baltimore, MD 21201

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify) in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

MULTIPLE INJURIES

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

{

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy
performed?

10 Yes 20 No

24b. Were autopsy findings
available prior to
completion of cause
of death?

10 Yes 20 No

25. Was case referred to medical
examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital: 10 Inpatient 20 Outpatient 30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural

20 Accident

30 Suicide

40 Homicide

50 Pending
InvestigationX0 Could not be
determined

28a. Date of Injury

(Month, Day Year)

11-16-99

28b. Time of
Injury

7:02 PM M

28c. Injury at
Work?

10 Yes 20 No

XX

28d. Describe how injury occurred

HIT BY TRAIN

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)

ON TRACKS

28f. Location (Street and Number or Rural Route Number,
City or Town, State)

OREMS & GOLDEN RING ROAD

BALTIMORE, MARYLAND

29a. Certifier
(Check only
one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ronald S. Wade, Director

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

NOVEMBER 17, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARCO P. KOSK

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

MAR 29 2000

32. Registrar's Signature

R. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42886

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Hilda Susan Schneeman

2. Date of Death

December 27, 1999

3. Time of Death

10:30 P.M.

4a. Facility Name (If not institution, give street and number)

Potomac Valley Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral
Director

5. Social Security Number

578-22-9187

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 11, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1235 Potomac Valley Road

10f. Zip Code

20850

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: White

15. Decedent's Education
(Specify only highest grade completed)Elementary/Secondary (0-12)
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clayton Berk McClure

18. Mother's Name (First, Middle, Maiden Surname)

Viola Elliott Blume

19a. Informant's Name/Relationship (Type, Print)

Charles Foster/Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15808 White Rock Road, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Parklawn Memorial Park

Date

Feb. 15,
2000

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee



M00198

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. Multiorgan Failure

Due to (or as a consequence of):

c. Diabetes Mellitus Type II

Due to (or as a consequence of):

d.

Approximate
Interval Between
Onset and Death

Two Weeks

30 Years

Sequently list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical
examiner?
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending
Investigation
6 ☐ Could not be
determined28a. Date of Injury
(Month, Day Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier



29c. License number

D52261

29d. Date signed (Month, Day, Year)

December 28, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Alan R. Segal, M.D. 1299 Lambert Drive, Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

FEB 14 2000

32. Registrar's Signature


State
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42887

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

Baby Girl Stewart

2. Date of Death

September 27, 1999 8:42pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral
Director

5. Social Security Number

Unknown

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9-27-99

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2333 Bellevue Avenue

10f. Zip Code

20785

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,
Black, White, etc.

Specify: BLACK

15. Decedent's Education
(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Nashira Stewart

19a. Informant's Name/Relationship (Type, Print)

Nashira Stewart/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2333 Bellevue Ave - Hyattsville, Md 20785

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of
cemetery, crematory or other place)

Disposal Johns Hopkins Hospital

Date

9/28/99

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Deborah Ekins

22. Name and Address of Facility

SHH- 600 N. Wolfe St - 21287

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line.Immediate Cause (Final
disease or condition
resulting in death)

a. Termination 2° to Fetal skeletal dysplasia 10 min

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate
Interval Between
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide
5 ☐ Pending Investigation
6 ☐ Could not be determined28a. Date of Injury
(Month, Day, Year)28b. Time of
Injury

M

28c. Injury at
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
and manner stated.

29b. Signature and title of certifier

Ernie Graham MD

29c. License number

Reg-000

29d. Date signed (Month, Day, Year)

4/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ernie Graham MD 600 N. Wolfe St - Bk Hb. Md. 21287

31. Date filed (Month, Day, Year)

APR 6 2000

32. Registrar's Signature

James B. Sparks

State
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42888

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) Christian Jackson				2. Date of Death Month August Day 9 Year 1999		3. Time of Death 10:30 AM	
4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore	
5. Social Security Number Unknown		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. _____		8. Date of Birth (Month, Day, Year) 1 20	
Usual Residence of Decedent				9. Birthplace (State or Foreign Country) MD			
10a. State MD		10b. County		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1214 McCulloh St				10f. Zip Code 21217		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) U/A College (1-4 or 5+) U/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U/A		16b. Kind of Business/Industry U/A	
17. Father's Name (First, Middle, Last) Unknown				18. Mother's Name (First, Middle, Maiden Surname) Crystal Jackson			
19a. Informant's Name/Relationship (Type, Print) Crystal Jackson / mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 McCulloh St - Balto. Md. 21217			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) Disposal		20b. Place of Disposition (Name of cemetery, crematory or other place) Johns Hopkins Hospital		20c. Date 8-10-99		20d. Location - City or Town, State Baltimore, Md.	
21. Signature of Funeral Service Licensee Deborah Evans				22. Name and Address of Facility 600 N. Wolfe St - 21287			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gross Prematurity. Due to (or as a consequence of): b. Premature labour Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 1 hr. 20 minutes	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier James J. Russell M.D.				29c. License number D15410		29d. Date signed (Month, Day, Year) 8/9/99.	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James J. Russell M.D. Johns Hopkins Hospital Baltimore Md. 21287.							
31. Date filed (Month, Day, Year) APR 6 2000				32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202.635.1234.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#21 perPHYG782 4/10/2000 EW

Certificate of Death

Reg. No.

99 42889

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

BRENDON JOSEPH KING

2. Date of Death

NOVEMBER 28, 1999

3. Time of Death

9:50 PM

4a. Facility Name (If not institution, give street and number)

SAINT JOSEPH MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral
Director

5. Social Security Number

0

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

NOV. 28, 1999

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

BOWIE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3108 TWIGG AVENUE

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

JEFFREY

L.

KING

18. Mother's Name (First, Middle, Maiden Summa)

TIANNA RENE ALVES

19a. Informant's Name/Relationship (Type, Print)

MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3108 TWIGG AVENUE, BOWIE, MARYLAND 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HOLY REDEEMER

Date

4-19-00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

James Eagan M.D.

22. Name and Address of Facility

SAINT JOSEPH MEDICAL CENTER

7601 OSLER DR., TOWSON, MARYLAND 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate
Interval Between
Onset and DeathImmediate Cause (Final
disease or condition
resulting in death)

a. EXTREME PREMATURITY

Due to (or as a consequence of):

Sequentially list conditions,
if any, leading to immediate
cause. Enter Underlying
Cause (Disease or injury
that initiated events
resulting in death) Last

b. CHORIOAMNIONITIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PRETERM LABOR

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings
available prior to
completion of cause
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,
City or Town, State)29a. Certifier
(Check only
one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Adelmo Marana, M.D.

29c. License number

D 20446

29d. Date signed (Month, Day, Year)

11-28-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADELMO MARANA, M.D., 7600 OSLER DRIVE, TOWSON, MARYLAND 21204

State
Registrar

31. Date filed (Month, Day, Year)

APR 10 2000

32. Registrar's Signature

Barbara S. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42890

AMENDED ITEM #17 PER FH G782 4/17/2000 AH

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DEREK DAVIS				2. Date of Death Month 09 Day 02 Year 1999		3. Time of Death 4:25pm	
	4a. Facility Name (If not institution, give street and number) Mercy Medical Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number none		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 2, 1999	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 8003 Woodgate Court				10f. Zip Code 21244		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) none College (1-4 or 5+) none				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) none		16b. Kind of Business/Industry none		
17. Father's Name (First, Middle, Last) unknown CHARLES EDWARD BLACKWELL				18. Mother's Name (First, Middle, Maiden Surname) Deborah Rebecca Langley				
19a. Informant's Name/Relationship (Type, Print) Mercy Medical Center				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 St. Paul Place Baltimore, MD 21202				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place) in state		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								0 weeks
a. Extreme Prematurity								
Due to (or as a consequence of):								
b. Probable overwarming & SEPSIS								2 weeks
Due to (or as a consequence of):								
c.								
Due to (or as a consequence of):								
d.								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MATERNAL GENITAL HERPES Premature Rupture of MEMBRANES MATERNAL HIV (+)								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Susan J. Dulkerian, MD		29c. License number D0043985		29d. Date signed (Month, Day, Year) 3/27/2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan J. Dulkerian, MD; Mercy Medical Center; 301 ST PAUL PLACE, BALTO MD 21202								
31. Date filed (Month, Day, Year) APR 17 2000				32. Registrar's Signature Beverly S. Sparks				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 99 42891

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

John Doe (unknown 99-316)

2. Date of Death

Month Day Year
DEC. 12, 1999

3. Time of Death

12:50 PM

4a. Facility Name (If not institution, give street and number)

OCEAN REEF DEVELOPMENT & BAY

4b. City, Town, or Location of Death

OCEAN CITY

4c. County of Death

WORCESTER

Funeral
Director

5. Social Security Number

unk

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

unk

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

unk

9. Birthplace (State or Foreign Country)

unk

Usual Residence of Decedent

10a. State

unk

10b. County

unk

10c. City, Town or Location

unk

10d. Inside City Limits

☐ Yes ☐ No

unk

10e. Street and Number

unk

10f. Zip Code

unk

10g. Citizen of What Country?

unk

11. Marital Status

unk

☐ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☐ No

If Yes, Give Year or Dates: unk

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unk

College (1-4 or 5+)

unk

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

unk

16b. Kind of Business/Industry

unk

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type, Print)

O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Penn Street Baltimore, MD 21201

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Atherosclerotic Cardiovascular Disease Complicated by
Alcohol Intoxication and HypothermiaApproximate
Interval Between
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) AT SCENE

27. Manner of Death

☐ Natural ☐ Pending investigation
☐ Accident ☐ Suicide
☐ Homicide ☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)

Found: 12-12-1999

28b. Time of Injury

Found: 10:00 A

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

Subject exposed to cold

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Marsh Area

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ocean Reef Development and Bay, Ocean City, MD

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

DEC. 13, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore King M.D.

111 Penn Street, Baltimore, Maryland 21201

State
Registrar

31. Date filed (Month, Day, Year)

APR 24 2000

32. Registrar's Signature

Theodore M. King

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99 42892

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LORYN RENAE CARTER				2. Date of Death Month Day Year November 12, 1999		3. Time of Death 1845	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number N/A		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 0		8. Date of Birth (Month, Day, Year) November 12, 1999	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
Usual Residence of Decedent								
10e. Street and Number 1026 Adams Ave., Apt. 1C			10f. Zip Code 21804			10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: Black			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A		
16b. Kind of Business/Industry N/A			17. Father's Name (First, Middle, Last) Lorenzo Carter Sr.			18. Mother's Name (First, Middle, Maiden Surname) Dionne Lynn Veney		
19a. Informant's Name/Relationship (Type, Print) Dionne Lynn Carter/Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1026 Adams Ave., Apt. 1C, Salisbury, MD 21804					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens			20c. Location - City or Town, State Hebron, MD		
21. Signature of Funeral Service Licensee David H. Thompson			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last a. prematurely Due to (or as a consequence of): b. rupture of membranes Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier M. Friday MD			29c. License number D30050			29d. Date signed (Month, Day, Year) April 5, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Beth Lindsay, M.D. PRMC 100 E. Carroll St. Salisbury, MD 21801								
31. Date filed (Month, Day, Year) APR 18 2000			32. Registrar's Signature B. Sparks					

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 42893

Amended Item#8,9 perFHG786 8/9/2000 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Artimita Butler				2. Date of Death Month Day Year 07 30 1999			3. Time of Death 2:10 pm			
	4a. Facility Name (If not institution, give street and number) Prince Georges' Hospital				4b. City, Town, or Location of Death Cheverly			4c. County of Death Prince Georges			
Funeral Director	5. Social Security Number 579-28-8014		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 09-15-1916		9. Birthplace (State or Foreign Country) Washington DC.		
	Usual Residence of Decedent										
10a. State D.C.		10b. County		10c. City, Town or Location Washington				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number 1845 Harvard Street, N.W.				10f. Zip Code 20009-2347			10g. Citizen of What Country? United States				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Home Maker				
17. Father's Name (First, Middle, Last) Allen H. Moss					18. Mother's Name (First, Middle, Maiden Surname) Mattie L. Moss						
19a. Informant's Name/Relationship (Type, Print) Loretta Y. Braxton/niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 639 Farragut Street, N.E. Wash. DC 20017							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Cemetery		20c. Location - City or Town, State 8/6/99 Suitland. Maryland					
21. Signature of Funeral Service Licensee  CC0348				22. Name and Address of Facility Latney's FUNERAL HOME 3831 Georgia Avenue, NW Wash. DC 20011							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ATHEROSCLEROTIC DISEASE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  MD				29c. License number 00046776			29d. Date signed (Month, Day, Year) 8/3/99				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Provo 3001 Hospital Dr. Cheverly, Maryland 20785											
31. Date filed (Month, Day, Year) AUG 09 2000				32. Registrar's Signature 							

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 42894

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM HOPPER				2. Date of Death Month Day Year November 30, 1999				3. Time of Death 12:35 P.M.			
	4a. Facility Name (If not Institution, give street and number) 7865 Crilley Road, Apartment 487				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel			
Funeral Director	5. Social Security Number 214-12-3769		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 78		8. Date of Birth (Month, Day, Year) Nov 8, 1921		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 7865 Crilley Road #487				10f. Zip Code 21061		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unk		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk				16b. Kind of Business/Industry unk			
	17. Father's Name (First, Middle, Last) unk				18. Mother's Name (First, Middle, Maiden Surname) unk							
	19a. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Arteriosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. <u>Disease</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {										Approximate Interval Between Onset and Death	
	Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Skin Cancer</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <u>Inspection</u> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier <u>Joseph Pestaner, M.D.</u>				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) <u>August 1, 2000</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Joseph Pestaner</u> 111 Penn Street, Baltimore, Maryland 21201												
State Registrar		31. Date (Month, Day, Year) <u>AUG 29 2000</u>				32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-42895

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/cremation permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jacinto Sanchez		2. Date of Death Month Day Year September 16, 1999		3. Time of Death 11:47 A M
	4a. Facility Name (If not institution, give street and number) 3623 Rexmre Road		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 092-66-4012	8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 30 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	6. Date of Birth (Month, Day, Year) 12/26/68		9. Birthplace (State or Foreign Country) Trinidad		
Usual Residence of Decedent					
10a. State MD		10b. County		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 3623 Rexmre Road		10f. Zip Code 21218		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1988 - 1994		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: Black					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction		16b. Kind of Business/Industry Commercial	
17. Father's Name (First, Middle, Last) Gomez Sanchez		18. Mother's Name (First, Middle, Maiden Surname) Maria			
19a. Informant's Name/Relationship (Type, Print) Antonio Sanchez		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Astro Ct., Baltimore, MD			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee Lisa Scott per DVR		22. Name and Address of Facility Beard Funeral Home 552 Lewis St., Havre De Grace, MD 21078			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hanging Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown	
23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) Found: 09-16-1999		28b. Time of Injury Found: 11:30 A M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject hanged self.			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Closet		28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, Maryland			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Theodore M. King M.D.		29c. License number O.C.M.E.	
29d. Date signed (Month, Day, Year) September 17, 1999					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) MAR 30 2001		32. Registrar's Signature Benita S Sparks			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-42896

Physician
/Medical
Examiner

Funeral
Director

1. Decedent's Name (First, Middle, Last) FLORENCE BRADSHAW MOFFETT				2. Date of Death Month May Day 29 Year 1999		3. Time of Death 9:40 E	
4a. Facility Name (If not institution, give street and number) Fallston General Hospital				4b. City, Town, or Location of Death Fallston		4c. County of Death Hurford	
5. Social Security Number 215-01-2830		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 79 Yrs		8. Date of Birth (Month, Day, Year) 8/17/1919	
9. Birthplace (State or Foreign Country) Maryland							
Usual Residence of Decedent							
10a. State MD.		10b. County Harford		10c. City, Town or Location Forest Hill		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 2118 Putnam Road				10f. Zip Code 21050		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Person		16b. Kind of Business/Industry Electronics	
17. Father's Name (First, Middle, Last) Edward Souder				18. Mother's Name (First, Middle, Maiden Surname) Helen (unknown)			
19a. Informant's Name/Relationship (Type, Print) Carl K. Moffett /Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10 a,b,c,e,f			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Providence Cemetery		20c. Date 6/2		20d. Location - City or Town, State Fallston, Maryland	
21. Signature of Funeral Service Licensee <i>Benjamin W. Kintz</i>				22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland			
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or an aneurysm. List only one cause on each line. Acute Myocardial Infarction Due to (or as a consequence of): Sepsis Due to (or as a consequence of): Ischemic Bowel Due to (or as a consequence of):							
Approximate interval between Onset and Death 1 DAY 1 DAY 1 DAY							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Endstage Renal Failure						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>Andrew Nowakowski MD</i>				29c. License number D08096		29d. Date signed (Month, Day, Year) May 30, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDREW NOWAKOWSKI MD 125 N. Main St. Bel Air, MD 21014							
31. Date filed (Month, Day, Year) JUN 3 1999				32. Registrar's Signature <i>James S. Jones</i>			

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Copy of original certificate never filed / if in the event original is found destroy this copy ECW

1/3/02

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-42897

1- For State Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Beatrice Gladys Nichols			2. Date of Death Month Day Year June 24, 1999		3. Time of Death 6:20pm M	
	4a. Facility Name (If not institution, give street and number) 902 Lapidum Road			4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
Funeral Director	5. Social Security Number 242-20-2235	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	8. Date of Birth (Month, Day, Year) 11/01/1920	9. Birthplace (State or Foreign Country) North Carolina		
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County Harford	10c. City, Town or Location Havre de Grace		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 902 Lapidum Road		10f. Zip Code 21078		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		
	16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) Walter Granklin Spicer		18. Mother's Name (First, Middle, Maiden Surname) Pearl Brown		
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) C. Edward Nichols - Husband		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 902 Lapidum Road, Havre de Grace, MD 21078				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harford Memorial Grdns.		20c. Location - City or Town, State Aberdeen, MD		
	21. Signature of Funeral Service Licensee Julaine M. Smith per DVR		22. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non-Hodgkins Lymphoma		Approximate Interval Between Onset and Death				
	23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Unknown		23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify)		23d. Date of delivery Month Day Year		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier T. Biondo MD		29c. License number 042800		29d. Date signed (Month, Day, Year) 6/25/99	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Biondo MD 319 S. Union Ave, Hdg, Md, 21078							
31. Date filed (Month, Day, Year) JUN 02 1999		32. Registrar's Signature Benjamin S. Sparks					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2024.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

State Registrar

01/03/2002 Certificate never filed; may be a duplicate certificate/dhb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-42898

1- For
State
Registrar

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jacob McGhee				2. Date of Death Month Day Year APRIL 17, 1999		3. Time of Death 11:37 A ^M										
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGE'S HOSPITAL CENTER				4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGE'S										
Funeral Director	5. Social Security Number None		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days 7		8. Date of Birth (Month, Day, Year) Sept. 4, 1998		9. Birthplace (State or Foreign Country) Maryland								
	Usual Residence of Decedent																
10a. State MD										10b. County Prince George's		10c. City, Town or Location Cheverly		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 5456 Madison Way #10										10f. Zip Code 20784		10g. Citizen of What Country? U.S.A.					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)										16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) None		16b. Kind of Business/Industry None					
17. Father's Name (First, Middle, Last) Unknown										18. Mother's Name (First, Middle, Maiden Surname) Ramona Lynn McGhee							
19a. Informant's Name/Relationship (Type, Print) Ramona Lynn McGhee (Mother)										19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5456 Madison Way #10 Prince Georges, Md 20784							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										20b. Place of Disposition (Name of cemetery, crematory or other place) Mt Olivet Cemetery		Date 4/26/1999		20c. Location - City or Town, State Washington, DC			
21. Signature of Funeral Service Licensee Duplicate Certificate, FH no longer in business No signature										22. Name and Address of Facility Plunkett Funeral Home 2504 28th St N.E. Washington DC							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SMOKE INHALATION Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):														Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown										23c. If yes, outcome of pregnancy 1 <input type="checkbox"/> Live birth 2 <input type="checkbox"/> Fetal death 3 <input type="checkbox"/> Ectopic pregnancy 4 <input type="checkbox"/> Pregnant at time of death 5 <input type="checkbox"/> Other (specify) 9 <input type="checkbox"/> Unknown				23d. Date of delivery Month Day Year			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23e. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined										28a. Date of Injury (Month, Day Year) APRIL 17, 1999		28b. Time of Injury 11:00 ^M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred UNKNOWN	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) RESIDENCE										28f. Location (Street and Number or Rural Route Number, City or Town, State) APT. 10, CHEVERLY, MD							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier David R Fowler MD		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) REISSUED MAY 8, 2002			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201																	
31. Date filed (Month, Day, Year) MAY 17 2002										32. Registrar's Signature [Signature]							

State
Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Hospital Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-42899

Physician
Medical
Examiner

Funeral
Director

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 2026.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) LORRAINE ARVILLA LEATHER				2. Date of Death Month April Day 28 Year 1999		3. Time of Death 3:40 Am	
4a. Facility Name (If not institution, give street and number) Western Maryland Hospital Center				4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
5. Social Security Number 214-14-6109		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth Month Jan. Day 13 Year 1921	
9. Birthplace (State or Foreign Country) Maryland		10a. State Md.		10b. County Washington		10c. City, Town or Location Hagerstown	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 13619 Little Antietam Rd.		10f. Zip Code 21742		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (10-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Home		17. Father's Name (First, Middle, Last) David Finley Weaver	
18. Informant's Name/Relationship (Type, Print) John W. Leather (Husband)		18a. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13619 Little Antietam Rd. Hagerstown, Md. 21742		18b. Mother's Name (First, Middle, Maiden Surname) Maude Gray Warbel		19. Informant's Name/Relationship (Type, Print) John W. Leather (Husband)	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Rest Haven Cemetery May 3, 1999		20c. Location - City or Town, State Hagerstown, Md.		21. Signature of Funeral Director/Inseiner Dennis R. Davis	
22. Name and Address of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pneumonia		23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypotension Compromised Nutritional Status		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) May 3, 1999		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier Dennis R. Davis		29c. License number D34165		29d. Date signed (Month, Day, Year) April 28, 1999		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOHAMMED S. ALI 1500 PENNSYLVANIA AVE, HAGERSTOWN, MD. 21742	
31. Date filed (Month, Day, Year) MAY 07 1999		32. Registrar's Signature B. Sparks		33. Registrar's Title Registrar		34. Registrar's Office State Registrar	

Medical Certification: To Be Completed by Physician/Medical Examiner

Immediate Cause (Final disease or condition resulting in death)

a. **Pneumonia**

Approximate Interval Between Onset and Death

3-4 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last

b. **End stage Renal disease**

c. **Multiple Myeloma**

d. **Due to (or as a consequence of)**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

99-42900

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

MARIAN G. REIB

2. Date of Death

August 23 1999

3. Time of Death

0740

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral
Director

5. Social Security Number

190-48-4637

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-14-10

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10e. State

MD.

10b. County

WICOMICO

10c. City, Town or Location

PITTSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5250 MORRIS ROAD

10f. Zip Code

21850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILLIAM J. FOLEY

18. Mother's Name (First, Middle, Maiden Surname)

DOE IRENE LEMON

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH SHOWALTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5250 MORRIS RD. PITTSVILLE, MD., 21850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SALISBURY CREMATORY

Date

8-24

20c. Location - City or Town, State

SALISBURY, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Gastrointestinal hemorrhage, acute

Approximate interval between Onset and Death

12 hr.

Due to (or as a consequence of):

Gastric / duodenal ulcers

2 weeks

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0054997

29d. Date signed (Month, Day, Year)

8-23-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Michael Darnell 551 RIVERSIDE DR SALISBURY, MD

31. Date filed (Month, Day, Year)

FEB 09 2007

32. Registrar's Signature

Karen B. Spauld

State
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician
/Medical
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

02/09/2007 Certificate was misfiled in the Worcester County Health Department
Certificate was never filed nor registered.
Certificate filed today. okayed by Ms. Sparks *dh*

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. **99-42901**

1. Decedent's Name (First, Middle, Last) William Kemp Richardson, Sr.				2. Date of Death Month May Day 27 Year 1999		3. Time of Death 2:42 a	
4a. Facility Name (If not institution, give street and number) 131 South Washington Street				4b. City, Town, or Location of Death Havre de Grace		4c. County of Death Harford	
5. Social Security Number 220-20-0496		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) 05/28/1911	
9. Birthplace (State or Foreign Country) MD		10a. State MD					
10b. County Harford		10c. City, Town or Location Havre de Grace				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
11a. Street and Number 131 South Washington Street				11b. Zip Code 21078		11c. Citizen of What Country? USA	
12. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other		13. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Years		14. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		15. Race - American Indian, Black, White, etc. Specify: White	
16. Decedent's Education (Specify only highest grade completed) 11th		17. Decedent's Usual Occupation (On day of death or during most of working life. Do NOT use retired) Warehouse Supervisor		18. Kind of Business/Industry Government			
19. Father's Name (First, Middle, Last) Charles Alexander Richardson				20. Mother's Name (First, Middle, Maiden Surname) Florence Hackney			
21. Informant's Name/Relationship (Type, Print) Evelyn D. Richardson- Wife				22. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 131 S. Washington St., Havre de Grace, MD 21078			
23a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		23b. Place of Disposition (Name of cemetery, crematory or other place) Angel Hill Cemetery		23c. Date 5/29/99		23d. Location - City or Town, State Havre de Grace, MD	
24. Signature of Funeral Service Licensee <i>Eugene M. Smith</i>				25. Name and Address of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078			
26. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Carcinoma of lung with metastasis</p> <p>Due to (or as a consequence of):</p> </div> <div style="width: 60%;"> <p>5 Mon</p> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div style="width: 30%;"> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> <p>Due to (or as a consequence of):</p> </div> </div>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Chronic Renal Insufficiency Pneumonia						27. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
28a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
29a. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		29b. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
30a. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		30b. Date of Injury (Month, Day, Year)		30c. Time of Injury M		30d. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
30e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		30f. Location (Street and Number or Rural Route Number, City or Town, State)					
31a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
32a. Signature and title of certifier <i>B. B. B.</i> Medical Examiner				32b. License number D43115-		32c. Date signed (Month, Day, Year) 5-28-99	
33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6155 Union Ave. Havre de Grace, MD 21078							
34. Date filed (Month, Day, Year) MAY 28 1999		35. Registrar's Signature <i>[Signature]</i>					

